TOWER HAMLETS HEALTH AND WELLBEING BOARD

Tuesday, 29 September 2015 at 5.00 p.m. Committee Room MP701, 7th Floor, Mulberry Place, 5 Clove Crescent, London E14 2BG

This meeting is open to the public to attend.

Members:	**Representing**
Chair: Mayor John Biggs	Mayor
Vice-Chair:	
Councillor Amy Whitelock Gibbs	Cabinet Member for Health & Adult Services
Councillor Rachael Saunders	Cabinet Member for Education & Children's Services
Councillor David Edgar	Cabinet Member for Resources
Councillor Denise Jones	(Non - Executive Group Councillor)
Dr Somen Banerjee	(Director of Public Health, LBTH)
Luke Addams	(Director of Adults Services)
Debbie Jones	(Director of Children's Services)
Dr Amjad Rahi	(Healthwatch Tower Hamlets Representative)
Dr Sam Everington	(NHS Tower Hamlets Clinical Commissioning Group)
Jane Milligan	(NHS Tower Hamlets Clinical Commissioning Group)
Co-opted Members	
Dr Ian Basnett	(Barts Health NHS Trust)
Karen Breen	(Barts Health NHS Trust)
DengYan San	(Young Mayor)
Steve Stride	(Chief Executive, Poplar HARCA)
Dr Navina Evans,	(East London and the Foundation Trust)
Suzanne Firth	(Tower Hamlets Community Voluntary Sector)

Quorum: The quorum of the Board is a quarter of the membership including at least one Elected Member of the Council and one representative from the NHS Tower Hamlets Clinical Commissioning Group**.**

Questions: Before the formal business of the Board is considered, up to 15 minutes are available for public questions on any items of business on the agenda. Please send questions to the Officer below by **5pm the day before the meeting**.

Contact for further enquiries:
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Role of the Tower Hamlets Health and Wellbeing Board.

- To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
- To identify needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions are based on evidence.
- To prepare the Joint Health and Wellbeing Strategy.
- To be involved in the development of any Clinical Commissioning Group (CCG) Commissioning Plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan.
- To communicate and engage with local people on how they could achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. This will involve working with Local HealthWatch to make sure there's a continuous dialogue with the public to ensure services are meeting need.
- To carry out new functions as requested by the Secretary of State and as advised in guidance issued from time to time.

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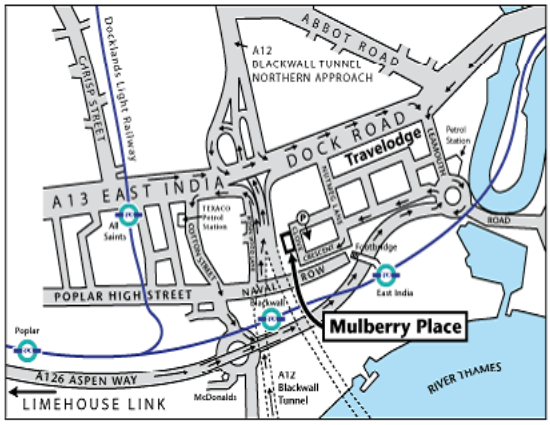

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PAGE NUMBER(S)

STANDING ITEMS OF BUSINESS

1. CHAIR'S OPENING REMARKS

Chair: Cllr Amy Whitelock Gibbs, Cabinet Member for Health and Adults Services will be chairing this meeting as the Mayor John Biggs is unable to attend.

1 .1 Welcome and Introductions

The Chair to welcome those present at the meeting and request introductions.

1 .2 Apologies

To receive apologies for absence and or lateness.

2. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING 1 - 14

To confirm as a correct record the minutes of the meeting of the Tower Hamlets Health and Wellbeing Board held on 7th July 2015.

3. ACTION UNDER DELEGATED AUTHORITY

To note any actions by the Director of Public Health Under Delegated Authority since the last meeting of the Board on 7th July 2015.

4. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS 15 - 18

To note any declarations of interest made by members of the Board. (See attached note of Monitoring Officer).

5. FORWARD PROGRAMME 19 - 20

To consider and comment on the Forward Programme.
Lead for item: Somen Banerjee, Director of Public Health, LBTH.

6. COMMUNITY INTELLIGENCE: TOWER HAMLETS COMMUNITY INTELLIGENCE 21 - 52

The report provides a short summary, key findings and recommendations from the 17 community intelligence reports completed by community and voluntary and sector organisations under the Community Intelligence Bursary Programme.

Lead for item: Dianne Barham, Healthwatch Tower Hamlets

ITEMS FOR CONSIDERATION

7. THEME: INTEGRATED CARE

7 .1 Integrated Care in Tower Hamlets - Update 53 - 66

The programme aims to change the way that patients receive care and the way that their care is organised and administered, with a focus on care being more coordinated and tailored to the needs of the individual.

Lead Officer: Jane Milligan, NHS Tower Hamlets Clinical Commissioning Group

7 .2 A Prevention-Orientated System 67 - 74

The paper sets out the current stage of development across local authority services, primary care, Barts Health and East London Foundation Trust. It also sets out the proposed areas of development: embedding MECC principles in all service pathways, aligning to the social prescribing programme and achieving economies of scale through delivery across a wider geographic footprint.

Lead Officer: Somen Banerjee, Director of Public Health

7 .3 Housing and the Integrated Care Agenda 75 - 82

The report identifies an opportunity for greater joint/integrated working between the social housing and health care sector and the potential beneficial outcomes this can have for residents.

Lead Officer: Somen Banerjee, Director of Public Health
Tim Madelin, Public Health, LBTH

8. HEALTH AND WELLBEING STRATEGY REFRESH - UPDATE 83 - 88

The report outlines the approach that will be taken to develop the refreshed Tower Hamlets Health and Wellbeing Strategy. All Health and Wellbeing Boards have a duty to publish and deliver local health and wellbeing strategies.

Lead Officer: Louise Russell, Corporate Strategy and Equality, LBTH

9. CHARTER FOR HOMELESSNESS HEALTH - ST MUNGO'S BROADWAY 89 - 96

This report outlines at a high level the homelessness strategy and specific initiatives to meet the health needs of people who are homeless.

Lead Officer: Somen Banerjee, Director of Public Health

10. ANY OTHER BUSINESS

To consider any other business the Chair considers to be urgent.

11. DATE OF NEXT MEETING

Date of Next Meeting:
Tuesday, 8 December 2015 at 5.00 p.m. in Committee Room MP701, 7th Floor, Mulberry Place, 5 Clove Crescent, London E14 2BG

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE TOWER HAMLETS HEALTH AND WELLBEING BOARD

HELD AT 5.00 P.M. ON TUESDAY, 7 JULY 2015

COMMITTEE ROOM MP701 7TH FLOOR, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON E14 2BG

Members Present:

Mayor John Biggs	(Chair)
Councillor Amy Whitelock Gibbs	(Cabinet Member for Health & Adult Services)
Councillor David Edgar	(Cabinet Member for Resources)
Dr Somen Banerjee	(Director of Public Health, LBTH)
Dr Sam Everington	(NHS Tower Hamlets Clinical Commissioning Group)
Jane Milligan	(NHS Tower Hamlets Clinical Commissioning Group)

Apologies:

Councillor Rachael Saunders	(Deputy Mayor and Cabinet Member for Education & Children's Services)
Robert McCulloch-Graham	(Corporate Director, Children's Services)
Steve Stride	(Chief Executive, Poplar HARCA)
Dr Amjad Rahi	(Healthwatch Tower Hamlets Representative)
Dr Navina Evans	(Deputy Chief Executive and Director of Operations)
Dr Ian Bassett	Barts Health NHS Trust

Others Present:

Dianne Barham	(Director of Healthwatch Tower Hamlets)
Tim Madelin	(Senior Public Health Strategist)
Esther Trenchard-Mabere	(Associate Director of Public Health, Commissioning & Strategy)
Sarah Castro	(Poplar HARCA)
Carrie Kilpatrick	(Interim Deputy Director of Mental Health)
Karl Marlowe	(East London and Foundation Trust)
Brian Parrott	Safeguarding Adults Board

Officers in Attendance:

Jamal Uddin	Strategy, Policy and Performance, LBTH)
Elizabeth Dowuona	Committee Services, LPG)

1. STANDING ITEMS OF BUSINESS

2. CHAIR'S OPENING REMARKS

MAYOR JOHN BIGGS (CHAIR)

Mayor Biggs welcomed everyone to this first meeting of the Board for this municipal year 2015/16. As the newly elected Mayor of the Council and Chair of the Board he proposed to attend its meetings and would be looking to learn more about the work of the Health providers. He noted that the focus of this meeting was on the Board's terms of reference and presentations on the work of the Health providers.

3. APOLOGIES FOR ABSENCE

Apologies for absence was received from Councillor Rachael Saunders, Cabinet Member for Education and children's Services, Councillor Denise Jones, Robert McCulloch-Graham(Corporate Director, Education, Social Care and Wellbeing), Dr Navina Evans (Deputy Chief Executive of East London and Foundation Trust) and Steve Stride (Chief Executive, Poplar HARCA).

3.1 Public Questions

The Board noted that no questions had been received from members of the public.

4. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

No interests were declared.

4.1 MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The minutes of the meeting held on 10 March 2015 be approved as a correct record.

5. TERMS OF REFERENCE, QUORUM, MEMBERSHIP, AND DATES OF FUTURE MEETINGS

The Committee Officer, Elizabeth Dowuona introduced the report.

RESOLVED:

That the Tower Hamlets Health and Wellbeing Board (HWBB) Terms of Reference, Quorum, Membership as attached to the Committee report and future meeting dates be noted subject to the following amendments to the Terms of Reference

1. That the following wording be amended in the Terms of Reference

   'Should the Mayor be unable to attend a meeting, the Cabinet Member for Health and Adult Services will chair the meeting in his place'.
   Should replace:
   'Should the Mayor be unable to attend a meeting, then the Cabinet Member for Health and Wellbeing will chair the meeting in his place.;

2. "Chief Officer – NHS Tower Hamlets CCG" replace
   "Chief Operating Officer - NHS Tower Hamlets CCG"

3. "Chief Officer – Barts Health"
   replace:
   "Chief Operating Officer - Barts Health"

6. FORWARD PROGRAMME

Dr Somen Banerjee (Director of Public Health, LBTH) reported that the board meetings were themed by the four priorities of the Health and Wellbeing Strategy. The next board meeting scheduled for September 205 would focus on Integrated Care and details of future board meetings would be available at the next meeting.

Action: Jamal Uddin (Strategy, Policy and Performance Officer, LBTH)

7. COMMUNITY INTELLIGENCE - HEALTHWATCH PERSPECTIVE

Dianne Barham (Director of Healthwatch Tower Hamlets) introduced the item.

Dianne Barham outlined the core functions of the Tower Hamlets Healthwatch and these were noted as follows:

- To provide information and signposting to enable residents to make informed choices about access to health and social services;
- To obtain feedback from local residents about their experiences of services provided and the services they needed for evaluation providers involved with commissioning, provision and scrutiny of care services;
- To make reports and recommendations about how those services could or should be improved;
- Promote and support the involvement of people in the monitoring, commissioning and provision of local services;

- To convey views and experiences of service users to Healthwatch England, advise the Care Quality Commission to carry out special reviews or investigations.

Dianne Barham referred to a dashboard of all information gathered in the last two years which would be visible on the Healthwatch website. In her presentation, she highlighted the analysis of comments collected from the Royal London Hospital. It was noted that the key themes ranged from how friendly and welcoming staff were, particularly reception staff, the quality of information available the clarity of information, the length of waiting times and patients transport. The Board discussed the tabled information provided, noting that overall, the comments received had been positive although there were concerns around staff shortages and delays.

Members welcomed the new system and considered this as good practice which in terms of outcome, was an innovative way of providing patients' satisfaction and a source of health provision directory for local residents, health and social officers. They however stressed the need for the services to respond to the feedback and ensure that there was an integration of the services with the aim of taking a holistic approach to the provision of health service.

Ms Barham undertook to provide a further report on the work of Healthwatch and how it shared good practice with other care services in the Borough.

It was reported that there would be a Health Conversation Event on 8 September 2015 which all Members were invited to attend. Dianne Barham agreed to provide feedback of the event at the next board meeting in September 2015.

Action: Dianne Barham (Director of Healthwatch Tower Hamlets)

8. HEALTH AND WELLBEING STORY - HEALTHY HOMES PROJECT

Dr Somen Banerjee introduced the healthy homes project, designed to increase awareness in both professionals and tenants about what can be done to tackle poor hosing conditions in private sector housing and bridge the knowledge gap of health and social care professionals on how to identify and refer poor housing conditions particularly around vulnerable tenants with long term conditions or with slower recovery from illness.

It was noted that the aim of the project was to increase the number of properties for vulnerable tenants who have had their conditions improved through environmental health intervention. A multi-faceted approach was undertaken by the project namely:

- Establishing referral mechanisms with the primary health care sector particularly various professionals who visited people in their homes in the course of their work.
- Increasing health professionals' knowledge, confidence and skills about private sector housing conditions and how poor conditions could be addressed.
- Developing a mobile reporting mechanism where those professional could telephone the relevant service directly for an assessment of the situation.
- Establishing a fund to enable small scale works to be carried out expeditiously, to improve the living conditions of those vulnerable tenants.
- Evaluating the wider cost benefits of the improvements achieved (considering in the cost of the deterioration of the tenant's condition and circumstances which would have invariably fallen on the Council).

Tim Madelin (Senior Public Health Strategist) presented a case study which illustrated the type of intervention and outcomes that could be achieved. The interventions were noted as follows:

- Referral was made by a support worker team leader at a sure start centre
- This included details of a young child (less than 1years old) who had been re admitted to paediatric intensive care unit due to bronchiolitis.
- The referral also noted the presence of damp and mould within the flat.
- The landlord applied for a green deal to fit a loft insulation and external wall insulation. He also was enabled to connected gas to the property, to enable a Gas Central Heating system to be fitted.

What made the difference:

- Training for front line staff to know about service and how to refer to it
- Easy referral path (including smart phone apps)

Members discussed the item at length, in particular, the obligations of the landlord. It was noted that where major works were required, professionals working collaboratively would seek to take enforcement action under the Landlord and Tenant Act 1985. Private property licensing and Landlord Accreditation schemes as adopted in the London Borough of Newham. On the question of whether the Council should not be considering these schemes, it was noted that the Council's Licensing Team had been consulted and their response to how the Council might consider adopting such a scheme was awaited.

It was agreed that the Director of Public Health discuss the matter with the Mayor outside the meeting on how the proposals on the Private property Licensing scheme might be expedited.

Somen agreed to bring a substantial item on Health and Housing to the next board meeting in September, scoping out the proposed role of housing.

Action: Dr Somen Banerjee (Director of Public Health)

9. CARE QUALITY COMMISSION REPORT

Dr Somen Banerjee, Director of Public Health introduced the report. He reported that the Chief Inspector of Hospitals had rated the services provided by Barts Health NHS Trust as inadequate following inspection of the trust's three main hospitals in London.

The Trust had already been placed in to Special Measures following the Care Quality Commission's report on Whipps Cross University Hospital which was published in March 2015.

Following that inspection, CQC decided to inspect both the Royal London Hospital and Newham University Hospital. Both were also been found to be inadequate.

The CQC had identified 65 areas where the Trust must make improvements. The areas of concern included the following:

- Safety and quality of services. "
- Leadership issues found at Whipps Cross were replicated at the other hospitals. There was a lack of engagement with the staff, low morale, high levels of stress and confusion among the workforce about who was in charge.
- Across the trust there was too little attention paid to safety, with failures in incident reporting and auditing,
- There were failures in dealing with and learning from complaints.
- The Trust's directors didn't seem to have confidence in their own data – a basic requirement in assessing their performance.
- There were unacceptably long waiting times and often, operations were cancelled.

Although many individual services required improvement, examples of good services were found at both Royal London Hospital and Newham University Hospital. There was a very committed workforce who although felt undervalued by the Trust leadership, they were valued by their patients and colleagues, and their local managers.

Barts Health NHS Trust as a whole had not made the progress in dealing with the findings of their previous inspection in 2013. The Inspector's conclusion was that if the trust was to turn round – then it must focus first on the culture and on the leadership issues so that it could effectively deal with all the individual concerns which we had been identified on the inspection.

The Royal London Hospital and Newham University Hospital were inspected in January 2015 over a period of three days by two inspection teams which included doctors, nurses and other specialists, hospital managers, CQC inspectors and experts by experience (people with personal experience of using or caring for someone who uses the type of services being inspected). They also made unannounced visits as part of the inspection.

The inspectors concluded that the trust lacked strategy and vision. The

Inspectors rated Newham University Hospital as Good for Urgent and Emergency Services. Patients felt well cared for and staff felt supported and there were excellent outcomes for people who had suffered a stroke. Royal London hospital was rated Good for Critical Care with patients positive about the treatment received.

Staffing levels in some areas were significantly below recommended levels and did not provide consistently safe care.

Bed occupancy was so high that patients were not always cared for on the appropriate wards, and the high occupancy was affecting the flow of patients through the hospitals.

Some patients faced delays of more than 18 weeks from referral to treatment and some patients had their surgery cancelled on several occasions due to a lack of beds.

During the previous inspection, in November 2013, inspectors had identified a culture of bullying and harassment. Although the trust commissioned an independent review, CQC found that the response had not been timely enough; the inspection team still had concerns

Members expressed disappointment about the extent and level of concerns in all three hospitals, particularly in safety and leadership, given that Barts Health NHS Trust was the largest NHS trust in England, serving a population of well over two million people, and home to some world-renowned specialties.

It was noted that the Trust Development Authority was working with the Trust to support improvements. Members considered that there was a need for officers to come up with proposals on how the Health and Wellbeing Board could influence the improvements at the Barts Health NHS Trust.

It was agreed that the Health and Welbeing Board would receive ongoing updates on the Barts Health Improvement Plan

Action – Karen Breen, Barts Health

10. EARLY YEARS: HEALTH VISITING SERVICE - FINDINGS FROM STAKEHOLDER ENGAGEMENT

Esther Trenchard-Mabere, Associate Director of Public Health, LBTH presented the report regarding the transfer of commissioning responsibilities for early years (0-5) public health services, specifically, the health visiting service (HV) and the family nurse partnership (FPN) from NHS England to the local Authority on 1st October 2015.

The Board noted the importance of these services in view of the Marmot Review 2010 that concluded that intervention in early years had a real impact on life-long health and the subsequent government decision to expand this service nationally.

The transfer, along with the significant expansion of the Health Visiting workforce, presented opportunities to strengthen the Health Visiting service and to develop new specification to improve integration with other services.

The Board also noted the health visiting service was central to ensuring that children and families had access to health promotion, preventive and early intervention services to support healthy physical, emotional, social and cognitive development.

Esther Trenchard-Mabere provided an outline of the health visiting service. Health Visitors, who were qualified specialist public health practitioners (registered nurses) worked as part of a mixed skill team supporting and educating families from pregnancy through to a child's 5th birthday. The aim of the health visiting service included keeping children healthy and safe, protecting them from serious disease through screening and immunisation and ensuring they were ready to start school.
The Family Nurse Partnership (FNP) offered an intensive programme of support for first time mothers (and fathers) under nineteen from early pregnancy up to the child's 2nd birthday.

The Board noted that some of the positive outcomes of the health visiting service which included; Improving life expectancy and healthy life expectancy; Reducing infant mortality; Reducing low birth weight of term babies; Improving breastfeeding initiation and prevalence at 6-8 weeks; Improving child development at 2-2.5 years and malnourishment; Reducing the number of children in poverty; Improving school readiness; Disease prevention through screening and immunisation programmes

The Board noted the National 4,5,6 Model as follows:

4 Levels of Service which set out what all families could expect from their local health visitor service:

1) **Community**: health visitors provide information on community needs and resources available e.g. Children's Centres

and self-help groups and work to develop these and make sure families know about them.

2) **Universal (the 5 key visits)**: health visitor teams ensured that every new mother and child had access to a health visitor, received development checks and received good information about healthy start issues such as parenting and immunisation.

3) **Universal Plus**: families could access timely, expert advice from a health visitor when they needed it on specific issues such as postnatal depression, weaning or sleepless children.

4) **Universal Partnership Plus**: health visitors provided ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child had a long-term condition.

a) The 5 universal health reviews

The 5 key visits were those that all families could expect under the universal level of service. They were also mandated (i.e. local authorities have committed to deliver) as part of the first 18 months of the transfer of commissioning; antenatal; New baby; 6 – 8 weeks; 9 – 12 months and 2 – 2 ½ years.

b) The 6 high impact areas

The purpose of the High Impact Area documents was to articulate the contribution of health visitors and describe areas where health visitors had a significant impact on health and wellbeing and improving outcomes for children, families and communities. These were noted as follows: Transition to parenthood; Maternal mental health; Breastfeeding; Healthy weight; Managing minor illness & accident prevention and Healthy 2 year olds & school readiness

Members regarded this as a crucial development in Tower Hamlets due to the high levels of deprivation and problems with child malnutrition picked up in schools and nurseries. The Board then watched a video about the Family Nurse Partnership with service users giving feedback on the success of the initiative and the ways that it had helped them. A representative from the Family Nurse Partnership explained some of the background to the initiative nationally and in Tower Hamlets. She outlined the eligibility criteria for support from the Partnership.

RESOLVED -

That the proposed Stakeholder Engagement process that had been carried out be noted.

11. MENTAL HEALTH: CRISIS CARE CONCORDAT

Carrie Kilpatrick, Interim Deputy Director of Mental Health and joint Commissioning presented a power point presentation on the Mental Health Concordat, a national agreement between services and agencies involved in the care and support of people in crisis. The concordat set out how organisations would work together better to make sure that people received the help they needed when they were having a mental health crisis.

It was noted that in February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. Since then five more bodies had signed the Concordat, making a total of 27 national signatories.

The Concordat focused on four main areas:

- Access to support before crisis point – making sure people with mental health problems could get help 24 hours a day and that when they asked for help, they were taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis was treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – making sure that people were treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by making sure people were referred to appropriate services.

It was expected that the Mental Health Care Crisis Concordat document would ensure that local Health and Wellbeing Boards (HWB) would bring together health and social care commissioners, the local community and wider partners, and support the crisis care concordat through their Joint Health and Wellbeing Strategies (JHWS). Joint working should include people experiencing mental health crisis.

The document set out certain requirements, including governance for action plans, and key areas to address (care pathways, resources, transient populations, drug and alcohol services and children young people). However, the key requirement is for HWBs to meet local circumstances and needs highlighted in the JSNA.

Local health and social care commissioners were expected to develop their own commissioning plans in line with any relevant JSNA or JHWS, and must be able to justify any parts of their plans which were not consistent with these.

Local partnership working and oversight of the strategic direction of mental health crisis care were therefore the key issues for Tower Hamlets Health and Wellbeing Board.

It was noted that to date, the Health and Wellbeing Board had adopted a Joint Mental Health Strategy, which, as part of its commitment to high quality services, has prioritised crisis resolution and a review of crisis pathways. This has laid a strong foundation for future partnership work.

The Tower Hamlets Mental Health Crisis Care Concordat action plan (Appendix 2) was agreed in March 2015 by the CCG, the Council, East London Foundation Trust (ELFT), Barts Health, the London Ambulance Service and The Metropolitan Police, and supported by eight local third sector organisations.

It was noted that he key messages for the Health and Wellbeing Board was that the Borough mental health services were good although it could be improved further. The following actions would be developed into specific project plans:

- Improve service user and carer experience of mental health crises at the Royal London Hospital Emergency Department;
- Obtain feedback from service users and carers with experience of local crisis services, and review options for improvement (with reference to the principle that People in crisis, and the carers of people in crisis, should be treated with dignity and respect and their expertise listened to);
- Develop improved on-line access to information and services through *the In the Know* on-line information service (on the Idea Store;
- Audit crisis plans and CPA plans (including for older adults) and reduce variability in quality;
- Reduce proportion of mental health crises where police are first to attend;
- Continue to ensure good response times and high quality services from LAS for Mental Health Act call-outs, and work to reduce inappropriate emergency ambulance crisis call-outs;
- Develop a mental health urgent care and crisis care dashboard, including monitoring ethnicity and age; and
- Engage service users and carers in monitoring the delivery of services according to expectations.

In line with wider NHS England priorities, the CCG had also been able to invest additional resources into the Early Intervention Service, which would increase the speed of response and offer NICE compliant interventions to people with their first experience of psychotic illness.

The NHS London Strategic Clinical Networks had drawn up commissioning standards and recommendations which will be considered when developing specific service proposals.

A senior partners group was in the process of being set up from the named signatories or their nominees to draw up detailed plans to improve support

police and ambulance response, and to propose improvements at the Royal London Hospital Emergency Department.

This group would also oversee timelines and progress on the other actions, such as the dashboard and the audit of crisis plans.

The Mental Health and Joint Commissioning Team had already engaged with service users to plan focus groups and surveys on service user experience, and to develop the content of an on-line information resource.

RESOLVED –

The Health and Wellbeing Board noted positive work covered on this issue and welcomed proposed further actions to support the delivery of the Mental Health Crisis Care Concordat.

12. HEALTH AND WELLBEING STRATEGY: REFRESH AND FINAL MONITORING 2013-2014

RESOLVED –

That the report be noted.

13. UPDATE ON PREVIOUS AGENDA ITEMS

13.1 Update on Liver Disease

Somen presented the HWBB with a progress update since it was discussed at the Health and Wellbeing Board meeting in September 2014.

13.2 Update on Breast Cancer Screening

Dr Somen Banerjee, Director of Public Health, introduced the report that detailed and highlighted a particular area of concern around breast cancer screening where there has been a decline of 6.5% in breast cancer screening coverage over one year.

Dr Banerjee provided some background to the breast cancer screening programme and coverage. He also provided data released by Public Health England in November 2014 showing a sharp reduction in breast screening coverage in Tower Hamlets (67.8% to 61.5%) in the year following transfer of responsibility and budget for screening to NHS England (April 2013 to March 2014). The downward trend appeared to be continuing and showed a consistent decline in coverage rates since 2013/2014.

A number of actions were put in place -

NHSE committed to an improvement plan to increase breast cancer screening coverage in Tower Hamlets. The plan included reintroduction of a targeted telephone outreach service to support women to access screening. This was to be based on a service successfully commissioned by Tower Hamlets PCT between 2007 and 2013 resulting in an increase in coverage from 53% to 67.8%.

Initially this would be by extending NHSE's existing contract with Community Links (a community organisation based in Newham) to work with Tower Hamlets GP practices. NHSE will subsequently tender for a provider to deliver this service in Tower Hamlets on a longer term basis. It was noted that

(i) The next active screening round in Tower Hamlets will begin in February 2016. The current service is therefore limited to contacting women invited during the last screening round between September 2014 and March 2015 who did not attend 2 appointments (1,500 women). Contact details held by the breast screening service may be missing or inaccurate for these women.

(ii) Central and East London Breast Screening Service (CELBSS) propose that only one appointment date/time is offered to each of this group of women. CELBSS is under pressure to improve performance by offering earlier invitations in the 5 other CCGs for which it provides a service, all of which have active screening rounds this year.

It was noted that Community Links had commenced delivery of a phone calling service for breast screening in Camden (which currently has a screening round in progress) and continued to deliver the same service in Newham.

RESOLVED –

The Health and Wellbeing Board recommended that assurance was sought from NHS England (London) that it was taking the necessary measures to reverse the decline in uptake of breast cancer screening. It further recommended that the Health and Wellbeing Board Executive Officers Group continued to monitor progress on breast cancer screening uptake.

14. ACTION UNDER DELEGATED AUTHOURITY

RESOLVED –

That the Board note the action taken by the Director of Public Health on behalf of the Chair and the Health and Wellbeing Board.

15. ANY OTHER BUSINESS

There were none.

16. DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Wellbeing Board would be held on Tuesday, 8 December 2015 at 5.00pm

The meeting ended at 7.45 p.m.

Chair, Mayor John Biggs
Tower Hamlets Health and Wellbeing Board

DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:-

Meic Sullivan-Gould, Monitoring Officer, Telephone Number: 020 7364 4801

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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Health and Wellbeing Board Forward Plan				
Date: November date tbc (moved forward from 8 Dec)				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
	Community Insight - Healthwatch Perspective	Dianne Barham		10 mins
Health and Wellbeing Strategy - Priorities	**Theme** - Early Years; and Mental Health			
	Emotional Wellbeing in Early Years	Esther Trenchard-Mabere		15 mins
	Transformation Plan - Children & Young People Mental Health and Wellbeing	tbc		15 mins
	HWB Stratgey Refresh Update	Louise Russell		10 mins
Discussion Items	Community Safety & Health		Involment of the Borough Commander	10 mins
Any Other Information		All		5 mins
Date: 12 January 2016				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
	Community Insight - Healthwatch Perspective	Dianne Barham		10 mins
Health and Wellbeing Strategy - Priorities	**Theme** - Long term conditions and cancer; and Healthy Lives			
	Long term conditions and cancer/integrated care item to be confirmed by EOG	tbc		
	Air pollution	tbc		15 mins
	HWB Stratgey Refresh Update	Louise Russell		10 mins
Discussion Items				
Any Other Information		All		5 mins
Date: 15 March 2016				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan	Chair		10 mins
	Community Insight - Healthwatch Perspective	Dianne Barham		10 mins
Health and Wellbeing Strategy - Priorities	**Theme** - Early Years; and Mental Health			
	Update on Health Visiting	Esther Trenchard-Mabere		15 mins
	Mental Health item to be confirmed			
	HWB Stratgey Refresh Update	Louise Russell		10 mins
Discussion Items	Barts' Health update		Update on the Barts Health improvement plan as agreed at July meeting	
	Update on Breast cancer screening		Regular updates agreed at the January 2015 meeting	
Any Other Information		All		5 mins

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Health and Wellbeing Board 29 September 2015	Tower Hamlets Health and Wellbeing Board
Report of: Healthwatch Tower Hamlets	**Classification:** Unrestricted
Tower Hamlets Community Intelligence Report 2015	

Contact for information	Dianne Barham Healthwatch Tower Hamlets dianne.barham@healthwatchtowerhamlets.co.uk

Executive Summary

This report provides a short summary, key findings and recommendations from the 17 community intelligence reports completed by community and voluntary and sector organisations under the Community Intelligence Bursary Programme. The Community Intelligence Bursary was a partnership programme with Healthwatch, the Clinical Commissioning Group (CCG), London Borough of Tower Hamlets and Tower Hamlets CVS. It was funded by Healthwatch and the CCG.

The reports are structured around the key themes of:

- Carers
- Older People
- Children and Young People
- Long-term conditions
- GP Services
- Eastern European communities
- Dual diagnosis

The aim of the report is to help shape the priorities and commitments for 2016-17 of Tower Hamlets CCG, Healthwatch, THCVS and the London Borough of Tower Hamlets. This is a draft report as the intention is to work with key partners, including the Health and Wellbeing Board, to develop overarching recommendations that will directly impact on the Health and Wellbeing Strategy, the Joint Strategic Needs Assessment and the commissioning intentions for the CCG and LBTH. The reports were reviewed by key partners at the Health Conversation event on 8 September with the intention of developing these overarching recommendations.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the report
2. To consider the cross cutting themes and recommendations to be fed into the Health and Wellbeing Strategy.

3. To note that the Community Intelligence Board partners will be drafting wider recommendations to come to the HWB at the meeting on 29 September 2015 for the Board consideration.

Appendices

- Draft Tower Hamlets Community Intelligence Report 2015.

DRAFT

Tower Hamlets Community Intelligence Report 2015

Introduction

What is the Community intelligence bursary

The aim of the Community Intelligence Bursary (CIB) programme was to ensure that the needs and views of the local community directly impact on how services are designed, commissioned and delivered in Tower Hamlets. The programme was developed by a partnership of Healthwatch Tower Hamlets, Tower Hamlets Clinical Commission Group, Tower Hamlets Citizens, Queen Mary University and Tower Hamlets CVS. In order to achieve this aim we developed local community and voluntary sector organisations to become community researchers in order to reach the unheard voices in the Borough.

Development of the programme

Community Intelligence Bursary Process

1. Bursary is open to voluntary and community organisations and individuals (supported by local organisation).
2. Successful groups take part in skills development programme and support.
3. All research gathered is combined into a single intelligence report
4. All groups/individuals who receive the bursary review the final intelligence report with key stakeholders and agree key issues and recommendations
5. The final community intelligence report together with key findings and recommendations goes to:
   - JSNA Board
   - CCG Governing Body
   - Health and Wellbeing Board
   - Health Scrutiny Panel
   - VCS Health and Wellbeing Forum
6. The impact of key findings /recommendations is reported back to the community.

We recruited 17 different organisations from across the Borough, who were then trained up in research skills by Queen Mary University and Tower Hamlets Citizens by a series of workshops and mentoring. This created a network of community researchers who not only had the skills but also had the contacts to carry this research out. There were a total of 33 researchers who were either staff members, volunteers of users from the different organisations. They were awarded certificates for their skills, experience and work at the end of the training.

Application Process

1. The Bursary will be advertised widely through voluntary and community sector channels.
2. Groups and individuals (supported by a local organisation) will be invited to submit a project proposal
3. A panel of Healthwatch, CCG, VCS Health and Wellbeing Forum, LBTH will short list and make decisions on the final projects. Applicants may be asked to an interview or be asked to work more closely with relevant partner organisations to refine their applications.
4. An independent evaluation of the programme is undertaken to enable learning to be applied to any future Bursary programmes

What did we want to find out

Healthwatch consulted with the CCG, public health, social services and the voluntary community sector as to the type of intelligence that would have the greatest impact on commissioning and service design in the next two to three years. These priorities became the areas of research for the community organisations. The priorities were:

1. Carers
2. Older people
3. Children
4. Young people
5. Cancer services
6. GP Practice
7. Integrated Care
8. Eastern Europeans
9. Dual Diagnosis

What did the bursary achieve?

The bursary achieved a number of aims but also had number of positive outcomes that were unexpected. They were:

- A richness in information.
- Over 1200 people have been engaged.
- Created a network of community researchers
- Created a list of contacts of different third sector organisations and local community groups.

- Equality of information from all genders, ethnicities and age.
- Created a number of peer support groups as a result of the research being conducted.

What happens next?

Each organisation had created their own independent report based on their research. Their reports were then collated and went on to form this summary report which will be taken for to the commissioners and other health providers within the Borough.

A public event will take place on the 8th September 2015 to bring together the organisations who have delivered the project, members of the public, commissioners, Tower Hamlets Health and Well-being Board, Tower Hamlets Public Health, voluntary and community groups and other key stake holders. The purpose of the event is to discuss the recommendations through workshops and see how we can work together in bringing change to these Health issues.

Crosscutting Themes

There were a number of key themes that emerged as commonalities across the different reports, which we are looking to draw out further at the public event:

- Many of the reports draw attention to the huge richness of voluntary and community sector resources in the borough. The reports suggest areas where the marginal benefit/cost ratio of linking in to VCS provision, by social prescribing and in other ways, are high – such as peer support for cancer patients, those experiencing dual diagnosis, and for people experiencing loneliness. The report flags the potential for more services to be delivered out of community buildings and mosques.
- There is acknowledgement too that funding cuts are having an impact on local voluntary sector infrastructure and this is putting existing community services at risk. The impact is likely to be felt most by older people, and highlights a challenge for both voluntary and public sectors to ensure that provision remains available to meet demand.
- Issues around awareness of and accessibility of services are recurring themes in Tower Hamlets given its cultural diversity. The research highlights some of the groups missed by current services, where outreach and culturally appropriate services might be targeted in order to combat specific gaps. These populations include Asian carers, Somali elders in need of residential care, and pregnant east European women.
- Several of the reports call for recognition of the role of carers and the burdens placed on carers by their caring responsibilities.
- There are a number of alarming stories that suggest the financial strains the NHS is under are having an unacceptable impact on certain need groups. The research pinpoints long waiting times for people needing sensory aids for example (a story of one man loosing the sight in one eye before he could get an appointment for example), and long waiting times for statutory mental health services that, one report suggests, are putting people off. The financial hardships faced by many people experiencing cancer was another strong finding.
- The impact of the 'wider social determinants' of health – particularly unemployment and housing - on health outcomes, recur through the reports. Lack of unemployment opportunities for working age men is cited as a major contributory factor to their experience of mental health problems, and the impact of the wide availability of cheap fast food is flagged by another as a key determinant of poor diet choice.
- Several reports cite evidence of health services not being sufficiently responsive to the needs of citizens and incidences where insensitivities and cultural inappropriateness led to poor patient outcomes. The need to better understand and to capture patient experience comes across strongly through the research.

1. Carers

Account 3 – "Who Cares?"

Organisation

Account3 Ltd is a Black Minority Ethnic (BME) women led, training and development social enterprise that was founded in 1991. They focus on finding innovative solutions to social issues and problems which hinder the economic development of local people. The company operates a one-stop shop approach to providing advice, support, resources and education to local people.

Summary

The research aimed to understand the experience of informal carers, their expectations and perceived barriers with regards to services. Also the effects that caring responsibilities have on their health, social and economic circumstances. Ultimately, asking the question "who cares for them?"

Account3 collected the views of 40 informal carers through a series of interviews and focus groups using participatory methods. They worked with St Hilda's, Black Women's Health & Family Support, The Carers Centre, The Somali Integration Team, and the Welfare Rights Advisor in order to ensure diversity of participants. All research questions were designed by informal carers who also led focus groups.

Key findings

The findings identify carers' journeys as emotional and psychosocial experiences that are at times completely shocking, baffling, overwhelming but also rewarding. The key issues that the research found were:

1. Recognition for informal carers

Many of the informal carers did not feel health and social care professionals acknowledged them as experts or "co-workers," despite them seeing themselves as full time workers. This led to a negative impact on their mental well-being, as they felt "worthless."

"I started to care for my mum since the age of 15, but I have been doing it properly since dad passed away, it is now 18 years." Female carer

2. Support for carers.

From the discussion it was evident that there was psychological distress, and an overall deterioration in health endured by the informal careers. Isolation and lack of support might prove a high burden and can result in distress or mental health problems.

"My marriage broke down as a result of me trying to care, the best I can for my daughter. It was too much for him to take. Her condition and my time spent in caring for her, he could not handle it." Female informal carer.

Carers frequently incur care-related costs. Many of them have experienced difficulties in obtaining either the Attendance Allowance or Disability Living Allowance. The reasons varied from the lengthy process, the number of hours required or difficulties obtaining a formal diagnosis. This resulted in the carer using their own money.

"I often had to make financial sacrifices…once I had to choose between my mum's needs and my daughter's needs for new shoes for school..." female informal carer.

From the research, it was clear that there are major issues around awareness of and access to health services. Many of the respondents found that they had problems either not knowing of the services available or issues with accessing the services.

Recommendations

The recommendations that have been put forward by the 40 informal carers:

1. To explicitly acknowledge the informal carer's expertise and knowledge of the person they are looking after as part of building a carer's confidence and resilience
2. To support the informal carers' own health and well-being. Talk about and offer information and support around the carer's need. Carers often think that their health needs are secondary to those of the person they assist. Their levels of stress are alarming, and some were crying out for counseling. Their psychological strain should be addressed with

support, counseling, and/or cognitive-behavior interventions.

3. Better identification and signposting. An over reliance on "self-identifying" means many continue to miss out on vital support services, which they have a right to as careers.
4. Need for simplification of forms.
5. Need for training. Informal carers requested access to training to enable them to perform their role better. Training suggested by participants in this study included training in raising confidence, First Aid, moving and handling.
6. To improve the taxi service that is currently being run out of a call centre based in Scotland. Those taking the calls have no local knowledge and drivers often do not understand the needs of the passengers with care needs, mobility issues etc.
7. Financial help for Carers. The financial burdens often put informal carers into a precarious situation, despite their role within the local and wider economy. Informal careers should be given extra financial help, failing to do so; can and does sometimes put the carer below the poverty line.

Black Women's Health & Family Support – "How do Careers Find Out about Local services?"

Organisation

BWHAFS is a community-embedded organisation which was created by local women of Somali heritage three decades ago. Its range of services include health advocacy for BAME, African and Somali-speaking women (many of whom are lone heads of households), their families and refugees. It supports on average 2,900 vulnerable service-users yearly.

Summary

BWHAFS noted a growing number of isolated older women, widows and carers who had no first-hand contact with the Borough's statutory or third sector services established to address their welfare, social and health care needs.

The research focused on how women from Somali heritage, accessed health services by undertaking one-to-one and group surveys with 30 hard-to-reach older female carers of Somali heritage. They also sought to understand their health and caring needs and priorities.

Key findings

Of 30 respondents, 27 older women interviewed were in contact with voluntary sector services including the Brady Arts Centre, Granby Hall, Wadajir, Ocean Somali Community Association (OSCA), Somali Integration Team, the Bromley-by-Bow Centre, Oxford House and the Legal Centre. Six had learnt of these services from family members, 2 through friends, 1 via a community centre, 2 via their GPs and 2 through emergency services while 5 undertook internet searches. When asked how health talks should be delivered, a majority of respondents suggested they should be delivered with support from bilingual interpreters, that illustrations should be featured and that they could also be publicised on screens in GP services. Some suggested regular talks.

Case study: Asha's story

Asha is of Somali heritage and over 65 years of age.

"*My son is ill. He suffers from mental illness. It came as a shock as all this was not communicated to me whilst I was in Somalia. I immediately started caring for him.*

At that time, refugees from Somalia were mostly concerned with their immigration status. There were no Somali organisations where I could go and no one supported me to get the right advice.

My son was hospitalised in a mental institution several times. I became so worried and stressed that I became ill. I struggled for years to care for him without any outside support. I didn't know where to go for help and my English skills were poor.

My son became suicidal. He attempted to kill himself several times. At that stage he did not have a permanent address in the UK and was not receiving any state benefits. On one occasion he became violent and pushed me. I fell and broke my arm.

In 2007, he was hospitalised once more. This time Social Services appointed a social worker for him. The social

worker supported him in getting welfare benefits and my son and I were referred to organisations for help.

I am an elderly person and I still care for my son but I also need to take care of myself. Because of language barriers, I could not go anywhere to access support.

A friend of mine told me about Black Women's Health & Family Support (BWHAFS) and the work they do for carers. Since then I have been attending the centre for general enquiries and support with my son's needs. I visit BWHAFS three times a week to socialise with other carers. I take part in their advice sessions, book my son's GP appointments and have joined the Lunch Club and sewing classes. Since attending my health has improved and I feel much happier within myself.

Overall, the research found that current services were not reaching these particularly vulnerable older women and carers due to technological and language constraints. These groups predominantly favoured the delivery of face-to-face information through community centre talks and GP services

Recommendations

1. Health service information should be targeted at women as they are the primary health and caring providers in families.

2. Important health messages should be promoted by the CCG and Healthwatch through a range of approaches. These should include partnerships with grassroots services that are able to engage with women from communities that are poorly served by current services including carers. Priority must be given to those from particularly disenfranchised communities such as those of Somali heritage who rely on oral traditions of communication and have limited reading, digital and English language skills. We think these groups could particularly benefit from health awareness activities and health talks and these could be provided through statutory/voluntary sector collaboration.

3. Health messages should be promoted through TV channels and touch screens at GP services in appropriate community languages so as to reach disenfranchised women and families through a range of approaches.

4. The CCG and Healthwatch should continue to work in partnership with small organisations to undertake further research into the changing needs of the borough's most vulnerable women and carers so as to support them in maintaining good health for themselves and their families and dependents.

Asian People's Disability Alliance – "Hidden Carers"

Organisation

Asian People's Disability Alliance is a grass roots disabled people's organisation. It is a user-led, needs-led, non-governmental and non-denominational organisation in its service delivery and campaigning. It provides culturally appropriate services to Asian disabled people, their carers and their families that mainstream services are often unable to provide.

Summary

The research was aimed at identifying Asian hidden carers who currently provide care and support to another person, yet are unrecognised for their commitment and do not have the formal support they require for their own physical and mental health needs.

The research looked at unsupported health needs for female Asian hidden carers. .

Many of the hidden carers were isolated and largely disenfranchised. Informal one to one interviews and small focus groups were held to gather their views. A total of 22 interviews were conducted.

Key findings

The key themes that researchers noted are as follow:

i) Lack of control and choice, especially in regards to finances

ii) No time for their own health and wellbeing

"I am not able to always communicate, expressing myself, I am disregarded and my wife has to be called, which makes me feel demoralised, belittled"

iii) Often not caring through choice, more as an expectation. Caring as a duty.

iv) No one asking them about how they feel, only this research.

"I felt lonely, there wasn't a shoulder to cry on, didn't want kids to see me"

"For services and support to offer a holistic approach that includes the needs of the carer and the person cared for and takes into account the carer's other responsibilities"

"As a carer when I seek support, it is only prescribed for my eldest son, who is under the adult disability team, however I have other children with medical conditions who need support physically and emotionally who are disregarded in receiving holistic care"

Case Study

A couple have 4 children, all with healthcare needs, the eldest has been diagnosed with having autism, potocki-lupski syndrome, is partially deaf in right ear, has arthritis, and his cartilages have not developed. He has a care package with social care.

Their second child has type 1 diabetes, rheumatism, anxiety and hypermobility. Their third child also has type 1 diabetes, suffers from urine infections and has a cyst on the left eye. Their fourth child has speech and language needs.

They only receive care support for their first child.

The mother suffers from the following conditions, enclosing spondylitis, osteoporosis, endometriosis, incontinence and their father suffers from the following conditions arthritis, chronic prostatitis, kidney stones, depression and anxiety, they are both carers for their children.

Recommendations

Short Term Recommendation:

i) Drop in Sessions to identify hidden carers and raise awareness of disability conditions and the support available.

ii) Training for hidden carers in health conditions, disabilities and caring roles.

Medium Term Recommendations:

i) Review the current mental health support services, and whether they are fit for purpose for the Asian community in Tower Hamlets.

ii) Develop a more holistic approach in health and social care support that takes into account the needs of carers, the person cared for and the family unit.

iii) A language appropriate campaign to raise understanding and awareness of hidden carers and the value of caring. This should use translated documents.

Long Term Recommendations:

i) A more culturally suitable informal and open service approach to support the Physical and Mental health needs of Asian Carers and hidden carers

2. Older People

Somali Senior Citizens Club – "Health and Social Care for Older Somali People"

Organisation

The Somali Senior Citizens' Group is an organisation that runs a number of services for the Somali community within Tower Hamlets.

Summary

Somali Senior's Citizen Club was commissioned to undertake an assessment of the present and future health and social care needs of older people (aged 55+) from the Somali community. The assessment also covered health, and housing and other welfare needs which impact on the need for social care.

The objectives of the project were to gather the views of older men and women in order to:

- Learn what the Somali community understand by care home services.

- Establish why the Somali community do not easily access care home services.

Key findings

The majority of participants were mistrustful of care home services and providers. The primary barriers to accessing services included lack of information, language barriers and access to a culturally appropriate service.

The following organisations provided outreach and venue support to the research:

- Al-Huda Mosque and Cultural Centre.
- Bustaan Radaa (Gate Housing Association).
- Queen Victoria's Seaman's Rest House.
- Somali Senior Citizen Club.
- Somali cafes.

75 older Somali people took part in the research via interviews and focus group discussions (24 women and 51 men). An overwhelming majority of these participants clearly stated that they don't want to go to care homes unless there is improvement in a number of areas. 5 Participants are happy to go to care homes as they are now. 55 want to see care homes run by staff with similar backgrounds. 15 others don't want to go to care homes at all.

Case Study 1

Mr Ali is an 82 year old Somali man who lives in a care home in the borough. When asked how he would like to see the care home in the future his answer was that he has been here for the last three years and wished all these three years that one day he would come across a Somali speaking person who can understand his needs.

"At many times I became angry and agitated because nobody speaks the same language as me that is why I like to be left alone in my room. Having someone who can speak my language will help me. I can tell my problems in my own language. This will help me and help reduce the isolation and loneliness I experience.'

Case Study2:

Ms Y, a 78 year old who lives in shelter home is very reluctant to go to home care as she thinks the home care is only for the people who have been abandoned by their families. She also believes that in a care home environment personal services can be delivered by anyone, regardless of their gender, which is religiously and culturally inappropriate.

"I don't want a man to wash me up, this is an embarrassing and very shameful"

Recommendations

1) In depth and detailed information to be available about current care homes and care providers.

2) More Somali speaking staff to be recruited to work in care homes and care services to address cultural and language barriers.

3) A consultation with a person's family is standard before a final decision over their care is made

4) To engage with community organisations that are able to reach out to individuals who may be left out and in need.

5) Somali organisations to run care home awareness sessions regularly in order to deliver appropriate messages to the wider Community

Year Here – "How do you want to live when you're 100 years old?"

Organisation

Year Here is a full-time postgraduate course in London designed to cultivate entrepreneurial approaches to entrenched social problems. It is immersive, action-oriented, and grounded in the daily experience of those at the frontline of inequality.

Summary

The research focused on how residents of Tower Hamlets experience ageing, use health care providers and engage with wider social support services. It looked into their needs and preferences of health and social care. They approached:

- People with limited social networks (and so at risk of becoming isolated).

- -People with moderate physical, mental health and mobility issues that restrict their ability to socialise and engage with the community.
- People who are currently facing social isolation and/or loneliness.

A total of 52 stakeholders were engaged through this research.

Key findings

The key areas of research were:

1. Wider social support

Every participant made a reference to the value that using wider social support services brings to their lives. Phrases such as "It has saved my life" and "It's my favorite part of the week" came up multiple times in the transcripts.

A few participants (17%) spoke about their experience of having to fight for funding. With this theme frequently came feelings of being "undervalued", "not cared about" or "forgotten about".

John, aged 87, spoke about a men's club he belongs to. He describes it as "fundamental to our lives – because we ain't got much going' for us these days". The men meet weekly at Brownfields community centre for a 'Men in Sheds' type group. They do activities such as woodwork alongside socialising and trips. The men that visit the club need more support as some suffer from mental and physical health problems. He spoke about their struggle to keep the club going because funding was being cut and he described how this makes him feel.

"Basically how it goes is – I used to live in the future when I was young and that. Then I lived in the present. Now I live in the past and no one cares about people that live in the past. They figure we're not worth it, that we don't really know what we're on about. So they close our stuff down."

If wider social support services are unsuccessful in their endeavor to stay open, then service users are more likely to become lonely or isolated as their contact hours with services will decrease. In our research we found that lonely people are almost twice as likely to visit their GP compared with patients who are not lonely and are more likely to visit A&E departments.

To maintain dignity and autonomy in older age is vital when providing good quality health and social care. They wanted face-to-face communication first, and then communication via the phone and then post as it would logistically work well occurred 6 times throughout the interviews. When asked if there was a place that they visited regularly to collect information GP surgeries was the only place that was mentioned more than once.

Having limited social networks has resulted in participants becoming lonely and suffering from mental health issues – depression and anxiety.

Case Study

Rose is 87 and lives in Poplar. She's suffered from multiple bouts of cancer, which she has beaten. She goes to one lunch club a week but struggles to get out due to her mobility. She has lost the motivation to leave her house on a more regular basis because of her anxiety.

"I'm just lonely and depressed and have panic attacks. Sometimes I pick up the phone just because I want to hear voices… I don't really know what else to do with my time. Apparently I might get an escort through the NHS (she laughs) not like one of those ones. Someone to take me out."

Rose has a counselor; she has only seen her counselor twice. She said it hasn't really helped her but she has really appreciated talking to an outreach worker who helps out at the 'Neighbors in Poplar' lunches. "It feels less formal". She explains that the informality of a chat is much more likely to engage her and inspire her to open up.

2. Health Care Appointments

GP Concerns- A large majority (92%) of participants expressed their fondness of being treated by their own GP every time they visited their practice. A third of these people spoke about times they had been seen by a different GP recently. This caused problems such as misdiagnosis and patients becoming agitated due to a "shake-up" of routine. A third of people also said they have experienced long waiting times (anything from 2 days to 2 weeks).

Health Care Appointments being changed. 3 interviewees raised the issue of having appointment times and dates pushed back to later dates. In all 3 cases this led to their health issues worsening and impacting their day-to-day lives.

Arnold lives in Poplar with his son. For the past 5 years he has been suffering with Glaucoma, he has partially lost sight in his right eye. He began to lose sight in his left eye, and his GP referred him to Moorefield Eye Hospital. His appointment was scheduled for February 5th (2015) this appointment was cancelled a week before and rescheduled to July 14th (2015). Whilst waiting for his next appointment Arnold` lost sight completely in his left eye and has now been told that it is unlikely that he will regain his sight.

"*What can I do, everything's gone wrong. The only thing that makes me happy is reading – I love books I could read all day… I ended up in hospital cos of my mental state, I was ill. And now I don't know what feels worse, now I can't read because I can't see. I can't do the thing I love.*"

General Practitioners. There are systematic, social and economic barriers to receiving GP care. From language barriers to financial situations and mobility combined.

Carers. of 24 one-to-one interviews with people being cared for at home two thirds (70%) of participants receive it from family members. We found evidence that this puts carers under a lot of pressure.

3. Support and Outreach Workers

Outreach and support workers were interviewed. The notes made included;

- Issues with pride from the elders.
- Better contact routes
- Navigators can be useful.
- Housing issues for elderly
- Social isolation
- Carers have limited responsibility.
- Family moving away.

Recommendations

1. Encourage collaborative funding. Organise networking events for services to discuss further growth and innovation together.
2. Citizens' Forums - so that they can have autonomy on how things are run and on how money is spent.
3. Information booklet about the different services that could be available to them.
4. Train support staff in signposting
5. Older patients drop in days at GP surgeries. There should be opportunity at least one day a week for the over 60's to get priority for an urgent appointment and reduce the waiting time between standard appointments.
6. Give younger patients a named GP. Having a named GP to go through the process of treatment with is very important for older patients, yet named GP's are only allocated after the age of 75.
7. GP Checklist - is a small form that a patient can fill in whilst at home or in the waiting room before an appointment. It acts as a reminder for listing all the issues that need to be raised during an appointment.
8. Intermediate job role in GP Centres. Someone who can engage with patients on a more social level within waiting rooms would help many patients overcome issues of social isolation and loneliness.

The Collective of Bangladeshi School Governors in Tower Hamlets (CBSG)

Organisation

The Collective of Bangladeshi School Governors in Tower Hamlets.

Summary

The aim of the research was to gather the views of the younger older people of the Bangladeshi community on the types of health and social care services they would like to see available to them in the future.

They conducted interviews, surveyed through questionnaires, and held a workshop to gather the views of Bangladeshi people (aged between 45 and 60). A total of 50 people were interviewed - 21 of whom

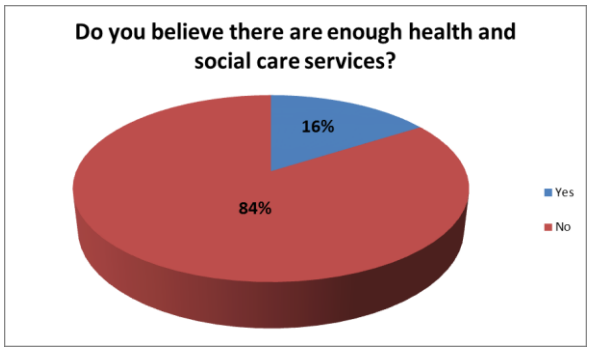
were female and 39 males. They also carried out a workshop which took place in the CBSG office in Brick Lane which 25 people aged between 45 and 60 attended.

Key findings

From the surveys, CBSG found:

A number of improvements were suggested for the GP service such as more GPs at the surgeries, shorter waiting times, more availability of appointments, organised and trained reception staff, telephone calls answered more quickly, thorough examinations where GPs do not rush, the need to explain prescribed medication, i.e. what it is for and how to take it, more interpreters, more female GPs and also GP surgeries to work on stressing the importance of cancellation of appointments so appointments can be given to someone else.

Many people mentioned past experiences of finding it very stressful to wait for long periods of time before being seen by the nurse or doctor.



14 people suggested technology/equipment provision for patient use at home

7 suggested supported housing/adaptations

12 suggested hospital letters to be sent in preferred language on request (Bengali).

A participant said that he had been dismissed from physiotherapy and given medication instead to help with his diabetic neuropathic pain, which has many side effects. He would prefer to go to physiotherapy instead and believes due to the shortage of physiotherapy services he is no longer able to attend thus he would like to see more physiotherapist places available in future.

Recommendations

1. Better technological support and equipment as a way of retaining autonomy for patients, but also a need to train them to use the equipment effectively.
2. Home adaptions
3. Care homes to be accessible to BME groups – by using bilingual carers.
4. Interpretation services available in health services
5. Better access to GP services
6. Improved GP service

St Hilda's East Community Centre – Older People's (55+) views on social care in Tower Hamlets

Organisation

St Hilda's is a lively Community Centre based on Club Row in the Weavers Ward of Tower Hamlets. It has various projects under one roof with excellent relationships to the age 55+ communities, as well as links to neighbouring community organisations across the borough.

Summary

The research looked at what older people (55+) thought about current older people's services and their expectations from Tower Hamlets as they get older. They collected views from the Caribbean, Bangladeshi and White British communities.

Interviews were conducted at various lunch clubs, centres and sheltered accommodation venues across the borough including:

St Hilda' East:

The Older People's Project Day Centre and Lunch Club. Boitok group -Bangladeshi Elders lunch club. Bondhon Project - supporting Bangladeshi women who are socially isolated and experiencing mental health issues. Food Co-op customers who met the criteria.

Sonali Gardens Day Care Centre - providing person centred care for Bangladeshi and other communities in Tower Hamlets. Shebadan Project - providing home care services to Bangladeshi and other communities.

LinkAge Plus, offering residents a range of social and health related activities

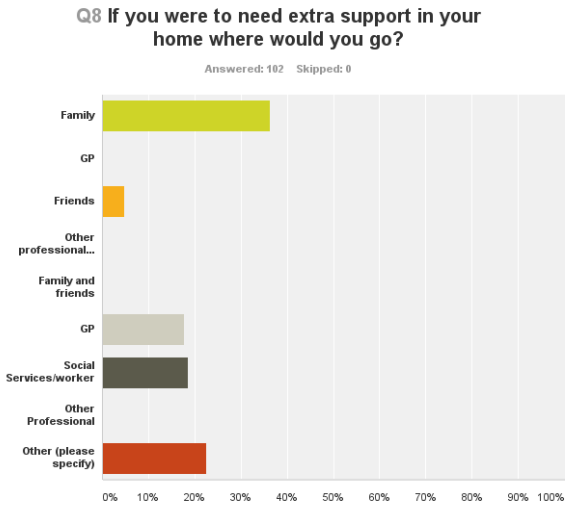
The Sundial Centre- day care and activities for older people.

Several focus groups and one-to-one questionnaires were held at **Sheltered Accommodation** venues across the borough including:

Hogarth Court - General needs/independent living. **Donnybrook** - Extra Care. **Sue Starkey House**, -Extra Care

Key findings

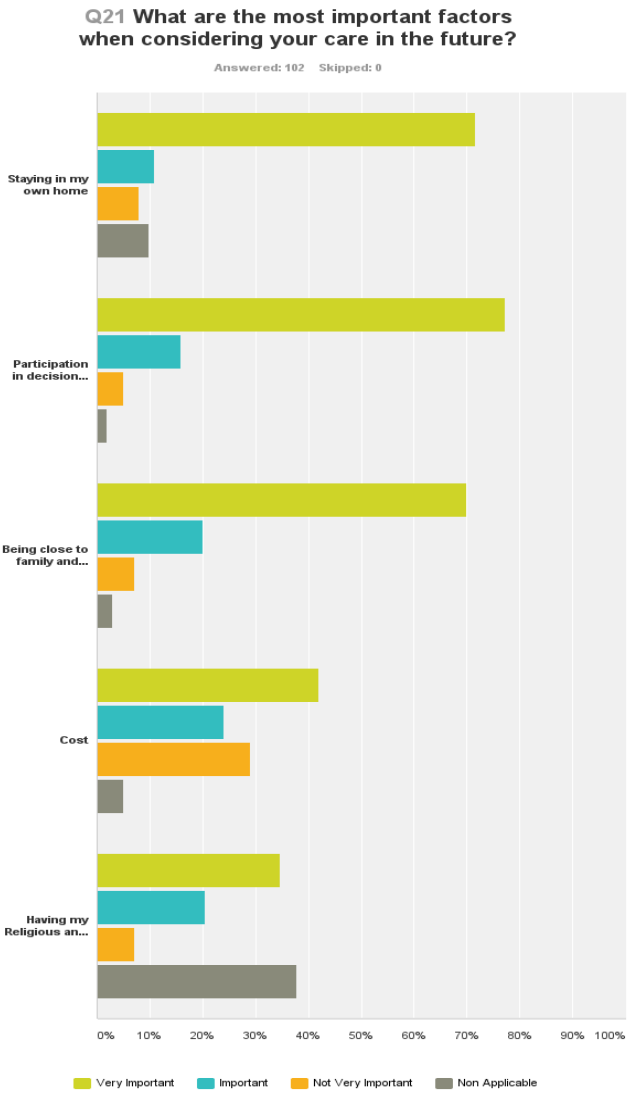
Key questions and findings included;



There is an overwhelming importance of Community Organisations and Services, because of the connection and trust service users have to them and their staff.

Just 32 participants out of 102 knew about all the services that were mentioned. 64 participants did not know about services or just knew about some services. Therefore, better promotion of services is needed and more outreach work.

When asked about the services that the participants thought would help the elderly, these included lively, sociable activities including those that keep people active. Things that would involve members of society.



When asked about their expectations of care, as they get older,57 said they would like to be cared for/looked after/supported/have extra support, adding comments such as: "With respect and care", "Like an individual."

Case Studies

Rabban Khan, Age 62 - In 2001 Rabban became sick after an accident at work and has not worked since. He separated from his family and lives alone. He became quite depressed due to his family situation, deteriorating health and being at home alone. Mr Khan was referred by his GP to *Community Options.* He has a good relationship with his support worker, who he believes treats him with respect and communicates with him well. He feels in general though, that not all services are as understanding of his needs or mental health issues and sometimes feels professionals are not

as caring. Without the social services he attends Mr Khan knows he would be isolated and feel more depressed. Attendance and socialisation at these events offsets his depression and is good for his wellbeing. Without them "*I would feel so alone and sad. I don't like lonely*" Mr Khan says.

Alvin Davidson, Age 89 - Alvin has a daily carer in the morning that he has had for some time now. Initially he had different people, which he did not like: *'some of them did not know how to care; some did not even know how to make a cup of tea. Things would go missing from my house and people get away with it and I cannot prove anything with all different people chopping and changing.*"

Alvin was not treated as individual. There was no scope for a relationship with his carer to flourish. He is more satisfied with his regular carer now, though he is often pushed for time and any added trips to the shops or to top up his electricity key rely on his carer's goodwill and time

Recommendations

1. Carers – this should include staff training which seeks to build a relationship-based practise and a continuity of staff.
2. Time allowance with carers - time with carers to be better matched to the needs of the individual
3. Services - more services and activities to take people outside of their homes.
4. Outreach Work
5. Better advertising of services
6. Sheltered accommodation- Clinics/advice sessions held weekly/monthly at sheltered accommodation venues. This will allow residents to be listened to and signposted where needed.
7. Support that prepares older people for staying in their homes

3. Children and Young People

Bangladesh Football Association – "Healthy Eating Research Project"

Organisation

The Bangladesh Football Association UK.

Summary

Research with children 6-11 year olds to find out their existing knowledge around healthy eating; their eating habits after school and before bedtime; their reasons for eating chicken and chips; and their parents attitudes to food.

The project worked with 30 children that regularly attend the football academy. They used a series of football exercises/activities to gather the information and also conducted surveys with 15 parents.

The following methods were used to get feedback from children and their parents:

a) **Warm Up** – Children were asked to do a stretch while warming up and answer "What is healthy?" Children took turns to do a stretch and say something related to healthy eating.

b) **Drink Run** – After a running drill, children chose drinks from 3 different boxes, one contained water, one contained fizzy drinks and one contained juices. Once they chose a particular drink they were asked to give a reason why they choose that drink.

c) **Dribble to Healthy Eating** – Children were asked to dribble with a ball and go to the appropriate station when called. Stations were labelled healthy / unhealthy. Each station had different types of food.

d) **Penalty Shoot Out – Child**ren took turns taking penalties. Afterwards they were asked if they ate chicken and chips after school. Every time they scored they had to give a reason why they ate chicken and c**hips. The aim was** to get at least 2-3 answers from each child as to why they eat chicken and chips.

e) **Food Chart** – children were given a food chart to record what they eat between 3.15pm and 9pm for a week. This was to help find out what they were eating after school, how much and the frequency.

f) **Focus Group**. After collecting the weekly food chart and doing the above exercises a group of 8-10 children were chosen and asked why they "really" eat chicken and chips, why they eat high amounts of food after school, what they drink a lot of at home, what their parents offer them, and whether their parents are encouraging them to eat all the time. This was to get in-depth information about the reasons for their eating habits.

g) **Survey with Parents** - A short survey was conducted with parents whose children participated in the project to find out their attitudes to food and healthy eating (and any barriers to healthy eating). They were asked questions in relation to their child's food chart for example, why they buy chicken and chips and what their child consumes during the evening.

Key findings

A) Baseline knowledge about healthy eating. Children are very knowledgeable, educated and have a good understanding of what food and drink is healthy for them and what is bad for them. The question is how many of them follow their understanding when buying food. Do they opt for a sandwich or McDonalds or do they order water/juice with their meal instead of coke. This is an area where more research needs to be done and some kind of education needs to follow where children are encouraged to implement what they learn. If children are encouraged to follow what they learn then they can influence their parents.

b) Eating habits after school. The food chart and the parent's survey were very similar. The food chart revealed around 20% of children had small snacks after school and a main meal around 7-8pm. The rest 80% had snacks, a mini meal and later a main meal. Those who had a main meal around 4:30pm had snacks up to bedtime.

From speaking to the parents the research found that around 40% of parents gave food straight after school and another 25% on the way home. However the vast majority 75% gave food at home as snacks but included a meal sometimes to keep the hunger away until the main meal at 7-8pm. The other 25% gave food as main meal and later snacks before bedtime. We feel the snacks and mini meals before the main meal is a contributing factor to increase in obesity in primary school children. Parents are also creating the lifetime habit which children will later find difficult to break.

c) Type of food and the amount children eat. The food children eat at meal times is generally healthy and wholesome and not much junk or fried food. Occasionally there is chicken and chips on the menu but on the whole children are eating cooked food such as spaghetti, pasta, chicken and mash potato, rice and curry, tuna salad, etc. However, the concern is the snacks they are consuming – crisps, biscuits, chocolate, chicken and chips, pizza, etc. They are also eating fruits and sandwiches in addition to this as a healthy option. We could not measure the amount children were eating and generally because it was a healthy eating research project parents and children did not want to be seen as unhealthy or overeating.

d) Reasons for Eating Chicken and Chips. From children's point of view it tasted good, and parents gave it as lunch or dinner and as a treat. From the parent's point of view the children wanted it/liked it, it was convenient, cheap, filing, and as a family they ate it as well when they did not cook. It was difficult to find alternatives and there were very few other food outlets and alternative food was expensive especially for families who wanted a quick meal.

e) Parents attitudes to food. Generally parents were well educated and placed importance on it. They wanted to give a balanced diet to their children. Around 10% felt they may be encouraging overeating in their children and they made sure their children finish their meal. The other 90% said they were more relaxed. They made sure their children did eat but did not encourage overeating. They said children were hungry after school and it was a task to find them healthy food to keep their hunger at bay until meal time. This was a challenge for them.

Recommendations

a) Continue healthy eating education. However, there needs to be more focus on whether children are implementing their learning when making decisions about food when they are out and about i.e. when they go shopping do they end up in McDonalds or a healthy cafe/food outlet. Do they order water or order Coke? We feel education needs to focus on implementation and encouraging children to eat healthily. They will then influence their parents. If children refuse to eat chicken and chips their parents will provide alternatives.

b) Educate Parents on overeating/snacks

c) Research on exercise and active living. There needs to be a separate piece of research on how much exercise children are doing after school.

d) More healthy food outlets in the borough. It should be easier to attain planning permission to open new healthy food outlets around primary and secondary schools. We would also recommend that tax relief and other incentives are given to cafes and shops selling healthy food at lower prices for children and families. Businesses participate in the scheme and get incentives to do so. Also, start a scheme where existing chicken shops participate and introduce healthy food like sandwiches, wraps, deli food, more juices, etc. and they are given incentives to buy equipment and to enable them to sell healthy alternatives at a lower price. They should be given incentives to participate in the scheme.

e) Provide after school food packs – including fruits, snacks and light healthy food so children are not given unhealthy snacks on the way home or when they go home. This should keep their hunger away until their meal time.

Leaders in Community – "Young Peoples Mental Health"

Organisation

Leaders in Community (LiC) Consultancy CIC is a pan-London youth led social enterprise that was established 6 years ago. They are passionate about creating avenues

for young people to drive social change in their environment. Their aim is "To inspire and empower a generation of young leaders to influence positive change within local communities and organisations".

Summary

The research surveyed young people to better understand their awareness levels and attitudes towards mental health, and gather suggestions on how best to tackle issues related to young people and mental health. Healthwatch Youth Panelists received training through the CIB process to become peer researchers and undertake the fieldwork research.

Young people have greater access to their peers so they were in the best position to conduct the research. They surveyed a total of 237 young people across LBTH aged between 15 and 24 years old.

Key findings

More teenage young men stated that mental health was an important issue to them than men aged over 20 years. The opposite trend can be seen for female respondents.

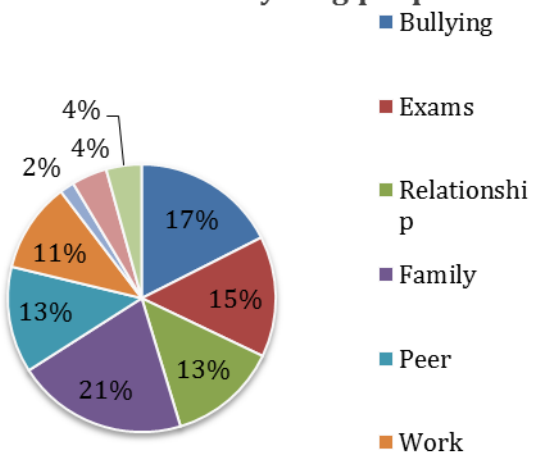
The vast majority of young people were unaware of both the national and local mental health services available to them. Aside from GP's, hospitals, Childline and Talk to Frank, awareness of other services that were presented to respondents was extremely low.

"My grandmother suffers from one form of mental health issue which is depression and one of my friends had previously been in depression, so it's quite close and meaningful to me. It is also significant to me because I want to be able to help my friends and family if a situation arises in the future and the fact that Mental Health is something which is under-addressed worldwide even though it plays a major part in everyone's wellbeing."

stigma (41%) attached to mental health illnesses, and fearing the possible adverse reaction of their loved ones (16%) if they were to discuss mental health issues with them.

21% of those surveyed stated that simply not knowing where to receive support would be a barrier for them in trying to access help.

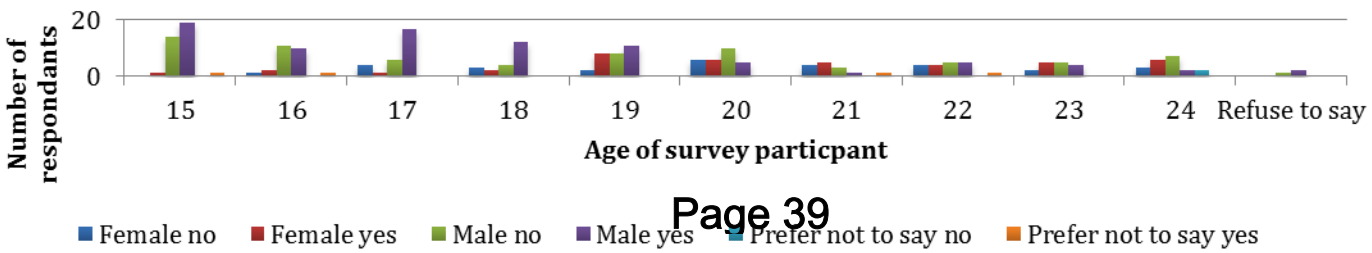
fig 2.4 What do you think could trigger or lead to Mental Health issues in young people?



Recommendations

1. Healthwatch and LiC to train more Peer Researchers from the Healthwatch youth Panel –so that they can build a social action campaign together on this issue.
2. The Youth Panel to meet with service heads from bodies such as the CCG, CAMHS and Public Health LBTH to discuss possible collaborative work as well as offer the services of the peer researchers to assist with on-going/external projects.
3. LiC to liaise with Youth Services LBTH/Young Mayor's Team LBTH to work collaboratively on the next steps of the Mental Health awareness

fig 1.7 Is Mental Health important to you?



4. Long-term conditions

Toynbee Hall – "What makes the biggest difference: Supporting Cancer Patients."

Organisation

Toynbee Hall is a 130-year-old community settlement that gives some of the country's most deprived communities a voice, providing access to free advice and support services and working with them to tackle social injustice. For the last four years, Toynbee has provided Macmillan benefits advice services for cancer patients and their families living in Tower Hamlets.

Summary

The research aimed to explore the kinds of support that would make the biggest difference for people with cancer and their families.

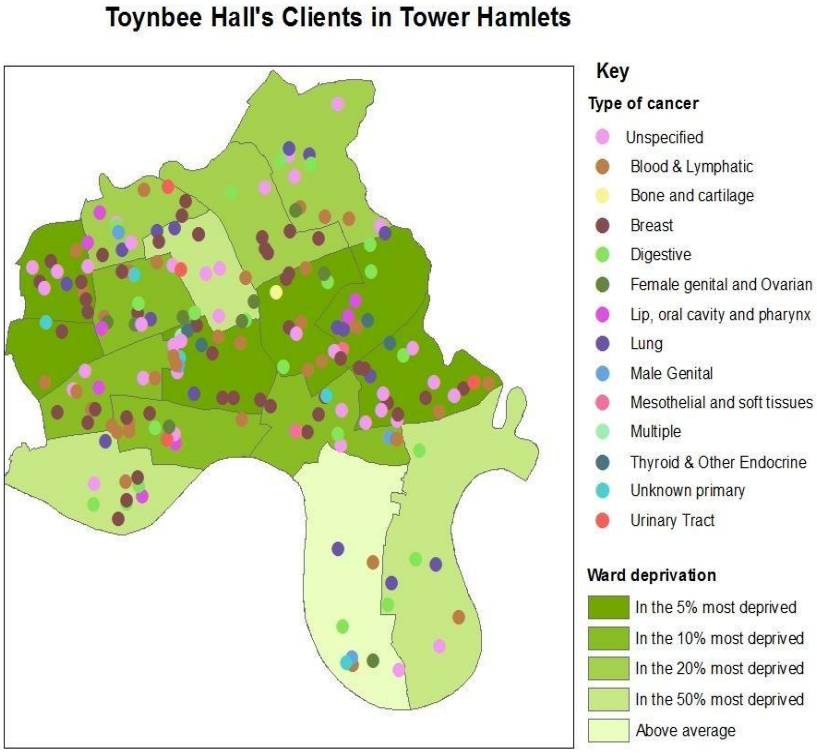
The following questions were asked:

- What support do cancer patients require?
- What services are available?
- How can services be improved to provide greater support?

They also conducted interviews and a focus group with cancer patients and their families. Sixteen people took part. They came from diverse backgrounds and varied in terms of age, gender, ethnicity, marital status, stage of cancer and cancer type. Thirteen of these respondents were cancer patients and three were patients' family members.

Key findings

The Geographical Information Systems (GIS) maps provide a visual overview of where cancer support services are based. They mapped the locations of 1182 anonymised Toynbee Hall clients, approximately 200 of whom live in Tower Hamlets and then added another layer to show the poverty in Tower Hamlets based on the Index of Multiple Deprivation (Department for Communities and Local Government, 2011). Different types of services were then identified in the map to show their availability in socially-excluded areas in Tower Hamlets.



Case Study

Linda's story - Linda is a Cypriot woman in her 60s who lives alone. She was diagnosed with cervical cancer in 2009 and Non-Hodgkin lymphoma in 2013. Following the researcher's introduction, Linda's recollection of her cancer journey focussed on a lack of support:

"Nobody came to see me; nobody asked me if I needed anything, nobody helped me in any way at all. … No services at all. … It chokes me up just to think about it. (Linda)"

Sharing how she was told about her first cancer, Linda said:

"When I opened the door, she [my GP] didn't ask if I was with anybody, she didn't ask me to sit down. … You can imagine my shock: I'm standing at the door and this doctor is telling me that I've got cancer. What do you do? (Linda)

Cancer has changed Linda, from '*a very outgoing person*' to someone who does '*not leave the house*':

If I don't go out anywhere, I don't spend any money. And when I go shopping… I can't spend more than £20. So I make sure what I buy is enough to see me for the whole week. (Linda)

For Linda, fear for her health and financial difficulties mean she has to '*stay at home 24/7*'. Her account strongly calls for financial assistance as well as psychological and social support for her, especially considering she does not have close contact with family and friends.

Understanding and positivity

The participants noted that '*sincerity*' (Zariya) and positivity help them cope better with the draining physical impact. Health professionals play a big part of their journeys, so doctors and nurses' accounts placed great importance on this need and this research suggests that they are largely helpful.

Some participants talked about the importance of clear communication, with positive accounts of the step-by-step explanations provided and more negative descriptions stressing the lack of clarity. Different experiences suggest the importance of patient-centered care that provides information that patients require and communication that suits their needs. Robert, a bladder cancer patient, for instance, described a negative experience. He felt treated '*as a body*' rather than as a person. His examination was intrusive and onerous to the extent that he delayed re-examination when he noticed symptoms returning.

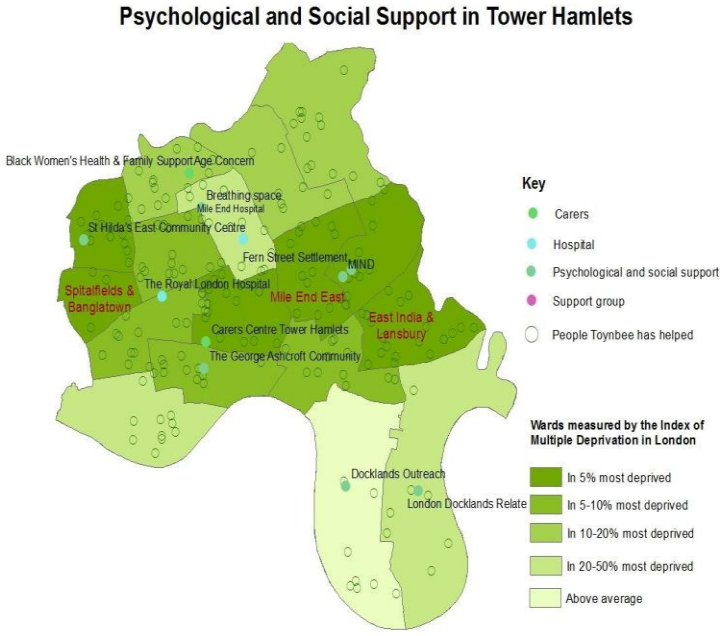
It makes my eyes water thinking about it [the examination]. They've got to put a camera up your penis … and you're lying down, and there's like, four or five people round you. …You feel bad in yourself for letting all these people round you messing with you. (Robert)

For a few other respondents, understanding their needs meant understanding their difficulty of waiting for three hours for a chemotherapy session. They said that it takes six hours to complete a session of treatment and they are often exhausted by the time they complete the treatment and make their way home. Reducing the waiting time would have been a clear improvement for them. St Bartholomew's Hospital, for instance, has been making efforts to do so.

Having someone to talk to

Some respondents, such as David and Mark, highlighted the importance of psychological therapy and workshops. But sometimes, other patients can also be a good source of psychological and social support. This was emphasized in our interview with Joseph, a fiercely independent older man who had previously worked as a nurse:

By speaking with the patients who had the same cancer treatment … you feel much better, you talk it out (Joseph).



From this map, we would also like to draw attention to the lack of psychological and social support services for people with cancer in three wards: Spitalfields and Banglatown; Mile End East; and East India and Lansbury. These three are among the 5% most deprived wards in London, suggesting a greater need for local service provision.

Resolving money worries

In this study, apart from those who had already retired or been unable to work because of other illnesses, all the cancer patients and family members had to either stop working or reduce working hours. They therefore believed that it was '*foundational*' (Debbie) to receive help in resolving their money worries.

Integration of services

Most respondents had multiple needs and issues. Many of them had benefits issues; Perm, Mark and Linda had housing problems; Zariya had a child care issue because her five-year-old daughter was not allowed in the hospital. This range of issues demonstrates the variety of needs among people affected by cancer. Integrated services are required to provide 'one-stop' access to support.

Recommendations

Short term:

- Hospitals should develop strategies to reduce patients' waiting time for treatment sessions, such as that for chemotherapy.
- Hospitals can investigate starting a support group in the borough or building on existing social groups.
- There needs to be an information pack which is updated regularly. The pack should include main services such as psychological and social support services, generalist, benefits and debt advice, exercise groups and older people's services. This information pack can be given to the patients at the point of diagnosis.

Medium term:

- Further training should be provided to help both doctors and nurses understand patients' experiences and develop better and more positive communication skills.
- Hospitals, Macmillan or other support services could set up a befriending scheme where volunteers who have recovered from cancer support patients in the hospital.
- Macmillan can act as an initial point of contact and be more proactive in referring people onwards to other services.

Long term:

- Health providers should work with the media, encouraging positive thinking on living with cancer.

Eden Care – "The Voiceless"

Organisation

Eden Cares objectives are not to replace existing provision, but work in partnership with other providers. They plan to engage service users in a culturally inclusive manner to increase and enhance their quality of life through friendship and advocacy. Their befriending and advocacy service works with adults and young people who are terminally ill or reaching the end of their lives.

Summary

Eden Care's research method was based on obtaining qualitative data through interviewing 10 service users from a BME background who had differing health needs. By using a 'one on one' interview method of gathering data researchers acquired first-hand information on how service users felt about NHS services.

Key findings

Case Study 1 - Almas Miah - Father of Mahima Begum

Condition: Cerebral Palsy

"I and my wife have to take turns staying awake at night time, in-case she chokes, and she has an epileptic fit, her medication has to be done on the spot."

"I could do with a lot more help, the only care my daughter needs is 24 hours care, throughout the rest of her life."

Almas strongly believes that the lack of communication between hospital staff and his family were contributing factors to the ill health of Mahima on the day she was

born. He is now faced with caring for his daughter for the rest of her life and struggles to meet all of her needs including providing all night supervision due to the risks of Mahima choking during the night. He also struggled to understand the complexity of words, medical acronyms and terminology used by some of the NHS staff. For Almas' wife, English was not her first language and to compound matters further, she also found their use of medical terminologies difficult to understand. Almas' wife would have benefitted from pre-natal classes delivered in the Bengali language in order to understand the process in having a baby and to become familiarised with the services on offer at the hospital.

Case 2: Rushna Khanam - Sister of Shopna Khanom

Condition: Terminal Cancer

"The G.P's kept on saying that it's probably nothing... gastric pains… they said it was kidney stones".

"They found out (after 6 months) that she doesn't have kidney stones, she's actually got stage 3 cancer".

In a desperate attempt to treat Shopna's illness her family took her abroad to Bangladesh and India to receive traditional folk medicine which was ineffective. This exacerbated the problem as the treatments given had almost killed her. Rushna believed that if the NHS had played a more active role in persuading the family not to seek treatment abroad this could have saved the family from the unnecessary journey.

Rushna also believes that there is a lack of awareness of the symptoms and conditions related to cancer especially around prevention, it's detection at the earliest stage and in how to cope with these life changing conditions.

Case study 3: Abu Mumin – Son of Late Saleha Begum

Condition: Died of Heart Failure

(Whilst in hospital) "She wasn't well and was on lots of medication, she needed a wash and all of our family members were there, and to our shock and surprise, two male nurses came to give my mother a full wash, we were horrified and shocked"…Why was her dignity and care not a priority "?

Abu Mumin's account in the shortfalls of the care provided to his mother where cultural and religious sensitivities have been overlooked goes to show that there is still a long way to go in order to truly make our health services more inclusive for our boroughs diverse needs.

In an interview, the Imam of East London Mosques, Shaykh Abdul Qayyum reinstated the importance of meeting the needs of the Muslim and wider community during their time of need.

Recommendations

1. Promote Bilingual Services

Translation services for Bengali speakers should be promoted extensively throughout Bengali and Muslim media channels including TV, Radio stations and print media. This would help raise awareness for patients to use the bilingual services on offer and to feel more confident in using NHS services independently.

2. Culturally Inclusive Training

NHS staff should also be given culturally inclusive, local training in order to understand Muslim sensitivities, especially when personal hygiene care is given by nurses of the same gender and not the opposite as this can easily offend.

3. Greater emphasis to be given to disabled patients

More awareness training for NHS staff to understand the unique needs for disabled patients. This awareness could be relayed through a scheme in where staff can have immediate access to patients' specific needs.

4. Community empowerment through locally delivered services

More services delivered through local organisations such as mosques and community centres being trained

in delivering awareness on campaigns on preventing common health illnesses.

5. Senior Management Team at the Royal London Hospital

To advance greater care, The Royal London Hospital staff should be more reflective of the local community including the senior management team.

6. GP Services

Al-Ishaara

Organisation

Al Ishaara is a local charitable company that has worked with and for deaf and hard of hearing people since 2008. They provide a broad selection of deaf friendly services in Tower Hamlets ranging from children's and adults Islamic classes, a Friday community sermon translated into BSL, a deaf youth service, marriage service, a dedicated deaf employment service and multiple events across the year to improve community cohesion across the UK.

Summary

The research sought to investigate access to GP Practices for the deaf community living in Tower Hamlets and also how GP practices could play a greater role as places to receive wider health and wellbeing support, i.e. linking patients into health programmes, community services, welfare support, social activities etc.

This research also sought to identify communication barriers and highlight the needs of the deaf and hard of hearing (HOH) community when accessing GP services.

Al-Ishaara gathered the views of parents and children with Special Education Needs on how services could work better together to improve the quality of their care. A combination of methods was used to gather information, from surveys, to focus groups.

Key findings

Key questions were asked to parents or adults who were deaf. They included the following;

Parents were asked what difficulties they face when visiting the GP as a deaf person or parent of a deaf child. The issues were:

1. Need to book BSL interpreter communications problem
2. Communication barriers need to communicate in BSL
3. Want to book interpreter but they didn't provide one
4. CSW level 3 is wrong should be interpreter level C
5. Communication problem with GP without interpreter (British Sign Language) "I needed British Sign Language interpreter at GP appointment but they sometimes don't provide a BSL Interpreter for me"

Q- Which health programmes are you aware of that benefit your child or yourself?

1. Most health programmes are not deaf friendly. They need to provide visible hand or BSL interpreter.

Q – Have you received any information from your GP regarding health programmes suitable for the Deaf?

"Very difficult [to make appointment], as I have to drive there because I can't use Type Talk and doctor doesn't have a text phone."

From the focus groups, it was found that both the hard of hearing and deaf groups received no information from their GP regarding health activities that are suitable for those that are deaf.

The Deaf Community is facing constant difficulty with telephone appointment booking systems, verbal prompts when their doctor is ready to see them, and rarely have a clear understanding of their diagnosis and treatment.

Waiting times for interpreters in GP appointments seem to be a massive problem. At the moment many people have to wait weeks to book a sign language interpreter who can make sure the patient and clinician are able to clearly communicate. There is an obvious link between these delays and poorer general health

Recommendations

1. The views of the local deaf and hard of hearing community about how GP Practices could play a greater role as places to receive wider health and wellbeing support need to be listened to.
2. The views of parents of children with Special Education Needs and children themselves need to be listened to on how services could work better together to improve the quality of their care.
3. Better forms of communication from all services through leaflets, videos and information boards in practices. Provide trained professionals in BSL to communicate effectively about the needs of the service user.

Asian Women Lone Parent Assoc

Summary

Through a focus group/workshop and one to one's, thirteen women were consulted on how to improve Asian lone mothers' access their GPs for their health and wellbeing needs; what would they like from their GP and what are the barriers to them accessing health services in Tower Hamlets.

The women ranged from ages 18 to 45 years old and consisted of a mixture of Indian, Bengali, Sri Lankan and Pakistani women who arrived in the UK through marriage and those born and brought up in the UK.

Most of the women attended GPs in the Limehouse, Poplar and Gill Street areas.

Key findings

In general it was found that the women had a positive experience in Tower Hamlets with health services for them and their children. The main use of health service was of their GP. Frequency of accessing their GPs varied for the women and much of this depended on their children's health needs. Examples included twice a week, once a month, once every two weeks, and twice a month.

It was found that the biggest challenges faced in trying to help women and their children to be healthy and well were in relation to access and support services including getting their children into a good school, support to find a job/volunteering, knowledge and support to access local exercise services for themselves and their children, wanting to swim but not knowing how to, finding healthy food expensive, managing their child's fussy eating habits particularly around not eating fruit and veg. Stress was a common challenge with two women saying they would like help to go on holiday so they and their children can feel better, managing own illnesses such as tuberculosis and eating habits.

With regards to mental health most of the women knew what this meant in that it related to 'your' mind. Four women did not know what this was. Interestingly over half did not know where to go to access mental health services. Three mentioned their GP as a source of help and one mentioned counselling.

Getting housing and a job were seen as the most common needs in regards to improving general health and wellbeing, examples given included getting a good permanent home, support with childcare, a positive change programme for women, help with jobs and support with housing to alleviate stress and help with mental health.

Specifically with sexual health most women would go to their GP. One mentioned not having a female doctor has prevented her seeking help and that she is now waiting for a female doctor.

Recommendations

1. To look at a holistic programme that addresses all the needs of the women impacting on their mental and physical health. Stress is significant factor in their lives so looking at activities that will help alleviate this would be key.
2. Health programmes would need to be highly sensitive in addressing the cultural needs to really have a significant impact on health and wellbeing and in further increasing their capacity to access health and wellbeing services in Tower Hamlets.

Stalwart Communities Limited

Summary

This study was designed to assess the need for, and possible benefits of, provision of a personalised educational health information service for families that have individuals with serious illness and chronic conditions. It aimed to provide an initial step towards evaluation of the resources that might be needed to deliver it. The family of interest is the group of related individuals whose lives are, or are likely to be, most affected by a health disorder – for practical purposes, the group living at the sufferer's home.

Researchers conducted a series of interviews with each family, with family members together and individually. Each family was asked to assess how well or otherwise it had been advised about the patient's problem and the future, and to give an idea where the best advice came from.

Twenty-six families were admitted into the study, ranging in size from more than 10 down to 4 members. Seven families gave their region of origin as in the United Kingdom, 11 in Asia, 5 in Africa, 2 in the Caribbean, and 1 claimed origin in more than one of these regions.

Key findings

Most of the information that families knew about the illness was from their doctors.

Families were asked a series of questions to understand the family's feelings. These included:

How much do the problems affect you? It was found that 92.3% said that it affected them a lot.

Over half of the families have said that they wanted to know more about their family member's disorder/illness.

While a majority of families drew information from both hospital-based doctors and general practitioners, individuals did so to a rather smaller extent – perhaps suggesting that access to doctors for all but the 'principal' caring family member may be more difficult.

A majority of the individuals studied are themselves made vulnerable by the contrast between satisfaction from factual information they gather and constant anxieties prompted by the suffering they see close at hand. Inevitably, some of them will fail to respond to some other of contemporary life's challenges. They may themselves become the patients of tomorrow.

Recommendations

1. Further interviews should be carried out as soon as possible, and that results – with a more thorough analysis, engagement with professionals and the third sector, and a wider discussion – be put together in the near future.

7. Eastern European Communities

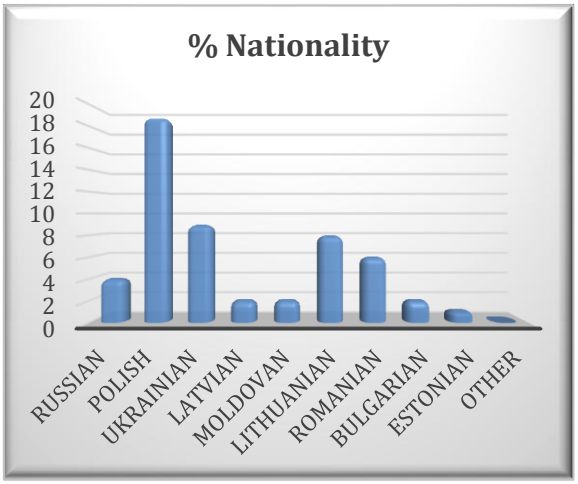
DASL's – "Research into the Health Care needs of people from the Eastern European Community in Tower Hamlets"

Summary

DASL aimed to acquire a mixture of feedback both from prospective health care service users and professionals who have worked with people from the Eastern European Community (EEC).

DASL worked with EEC service users and staff from Providence Row, NHS health visitors, The Fellow Centre, Doctors of the World, Vision Care for the Homeless, Tower Hamlets Community Mental Health Teams, Substance Misuse Services and GP Practices and Health Care Centres.

They used two questionnaires, one for individual service users and one for professionals. The service users were interviewed on a 1:1 basis and also in groups.

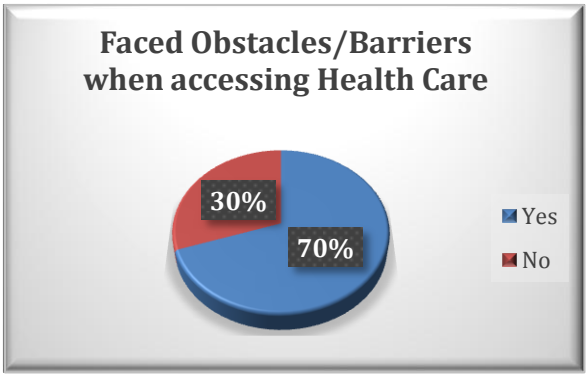


Key findings

All had accessed some form of health care, with the majority accessing a GP surgery, NHS Hospital and Dental care.

40% stated that the registration process for GP's was complex and lengthy, some waiting months before they were informed that they had been successfully registered.

Women who had been pregnant said they were unaware of any ante natal care or what they could access in the way of pregnancy support. One woman stated that she felt alone and frightened and didn't know where to turn for help.



Most stated that language was the biggest barrier with 77% saying this caused problems when trying to access health care along with the second being homelessness with 45% saying they experienced problems.

Antenatal care was raised by the women we interviewed and also by some of the professional agencies. It was stated that women at any stage of pregnancy were not aware of health care, ante natal classes, activities or follow up care required during pregnancy. Those that had accessed support found the language barrier confusing and felt they were unsure of health care requirements.

Some people we interviewed felt that a lack of adequate identification (e.g. passports, birth certificates, NIN cards, etc.) was a barrier to accessing health care and registering with a GP practice. Concerns were raised by one professional agency that when a person is trafficked or endured forced labour, very often they flee without any documents or identity.

Recommendations

1. Information about health care services for people from the EEC be available in accessible formats (language, electronically via websites, literature in accessible venues), specifically Polish and Russian. Extend the hospital telephone translation into English, Bengali and Polish & Russian

2. Translation be available for pregnant women at every stage of pregnancy – including written information about stages of care.

3. Registration at health care practices is explained or accessible in written information in EEC languages, or alternative information about where people can go if they are not eligible to register with a particular practice.

4. Better advocacy and support from specific agencies who are clearer of EEC issues

5. Some organisations are already putting into practice ways to improve access to health care for their service users, lessons and good practice should be shared across the sectors.

6. Training for health care professionals on the intricacies of the EU regulations and health care in the UK for EEC.

8. Dual Diagnosis

East London Radio– "Somalia Men – small problem or a big issue?"

Organisation

East London Radio (media) and Meducate Healthcare (public health) collaborated on this hugely important topic regarding dual diagnosis: mental health and substance abuse in regards to Somali men's health.

Summary

This project set out to investigate the potential link between mental health and substance abuse and the current service provision in a hard to reach group – the male Somali community in Tower Hamlets.

The aim was to answer three questions:

1. What are the experiences of people who have mental illness and a pattern of substance misuse?
2. What are the issues in relation to accessing services?
3. What would help people to move forward in their lives?

The research used face-to-face open questionnaires with the community. Additional case histories were transcribed, as the interviewees (45 interviews were conducted) wanted their stories told. Two podcasts were selected, as the narratives required a public platform. The age range of the participants was from 25 years to 79 years with a mean of 42 years.

Key findings

On questioning the male Somali community face-to-face the project became aware that the fundamental issue was not about a mental health diagnosis, but lay in an absence and misunderstanding of its manifestation.

Loneliness was expressed as a common state of 'mental health.' Isolation, worthlessness and hopelessness were given as descriptors of current 'feelings'. Prescription and over the counter medicines (analgesia) in particular were taken to dull sensory pain, like 'feelings'. The men expressed themselves in terms of feeling marginalised by lack of work opportunities, changing roles within their families and parenting gaps. Even in their own communities, they recognise that it is a spiral of decline that needs to be challenged.

The Somali community continue to feel relegated in Tower Hamlets, due in part to the written language difficulties. Somali language is an oral language, hugely descriptive and pictorial.

We cannot accept that mental health is just a medical problem. However, we can give testimony to the dearth of untapped skills and experience that already exists in the community. This should be explored, harnessed and utilised. There is an absence of career or coaching for this cohort; and the Job Centre and benefits trail has failed to harness their previous expertise, skills and knowledge.

In general, services seemed adequate, flexible and easy to access. Mental health seemed to be the more prevalent of the two topics (alongside substance abuse) and evidence suggested collaboration between other services to meet medical, social and psychological conditions.

93% were currently unemployed and the length of time was between 1 year and 12 years. However, 'feelings' were frequently mentioned. Descriptors around unemployment included 'hopeless'; 'waste'; 'sad'; 'angry'; 'unhappy' as the commonest themes.

2% of the participants declared they had mental health problems. Diagnosis was given medically and they were on antidepressant medication.

"I'm on tablets. My friends know. It helps me. When I had a job, I wasn't on tablets." - S.M 39 years, E.1.

Few knew how to start a conversation with their GP about how they were feeling.

"The doctor ask me what wrong, I say I have pain, he say where…..? I get tablets for pain in head" - O.H, E14

Mental Health remains a taboo topic within the community (Use of language, 'mad, bad') and is still misunderstood.

"I go to Germany. I have family there. Nobody knows me. I have bad demons." A.M, E.2 55 years

Loneliness and feelings of 'sadness' and 'despair' is often treated with painkillers, often prescribed, but more frequently self-medicated

Recommendations

1. The community wants to become empowered to be more responsive to their care needs:

We suggest development of an App (Software application) that is both written and pictorial telling people how to recognise symptoms of mental health/Substance Abuse. This could be developed in the schools within the Science and Technology curricula or indeed within QMU (Computing) and the community could have a say. An example of such an App is one that has been put together by "One in Four" aimed at teenagers. It addresses the difficult issue "What to say to the Doctor" when you are feeling depressed, lonely etc.

2. The need for formal education, such as ESOL in a place of study, not a community facility:

They identified the local University (Queen Mary), which they felt was most appropriate. This may create a revenue stream for the Institution and potential employment of Tutors. This visibility would enable them to engage in a mixed community and share a life-long learning platform.

3. Parenting skills were identified as a key issue. Grandfathers, uncles, brothers and fathers all stated they felt a cultural gap due, in part to language:

Formal parenting classes – particularly for men – many of whom have adopted many childcare responsibilities.

4. Football is a national sport in Somaliland. It is played in small groups within the community in public spaces within the borough:

We suggested that a football league is set up. The local authority could sponsor the kit. This would give out a clear message of 'Health for All' It would create a platform for stronger family bonds, time to talk and the added health benefits of engagement.

5. Men expressed an interest in their history and culture being on the schools curriculum and were willing to give their time voluntarily.

   Suggestions included participation in Black History month in the schools and perhaps access to the Whitechapel Gallery, to tell their stories.

In addition they expressed a need to engage with the wider community in the Borough and participate in the voluntary sector. This would enable them to create a working profile whilst they gain experience and build skills.

6. Meeting care needs alongside an ageing population- it was felt that keeping fit and active was very important as its benefits include mental health.

A designated care agency set up in the borough would benefit the community, in keeping people independent in their own homes whilst providing additional employment opportunities. This initiative may attract government funding and business loans and potential private investors.

Providence Row Housing

Summary

This explored the experiences of people with dual diagnosis in Tower Hamlets: A participatory research project conducted by Providence Row Housing Association's Peer Consultancy Team

Dual diagnosis refers to people who are experiencing mental health difficulties and use drugs and/or alcohol at the same time. This has long been a challenging area for support providers who struggle to define which should be viewed as the predominant underlying need and which should therefore be treated first. As a result, people with dual diagnosis have often found themselves being bounced back and forth between mental health and substance misuse treatment services.

Eleven separate target groups were identified for the community intelligence program. We chose to target people with dual diagnosis from homeless or insecurely housed populations.

Providence Row investigated the following questions:

1. What are the experiences of people who have mental illness and a substance misuse and/or alcohol issues (often referred to as dual diagnosis)?
2. What are the issues of accessing services?
3. What would help people to move forward in their lives?

The research team (three women and three men) all had lived experience of requiring support for a range of presenting needs. Creating a 'peer consultancy.'

The methods used in the research included:

Group Work: Participatory Appraisal - PA is a series of interactive, visual tools and techniques that can be used to help overcome barriers such as formal literacy and numeracy. PA sessions were delivered at 10 different sites across the borough. 56 people attended the sessions- 34: Male, 22: Female.

Interviews were also used in this research, 2 men were interviewed. One is White British and the other of mixed heritage. 1 woman was also interviewed. She was White British.

Key findings

1. Relationships – people placed a great deal of emphasis on feeling able to 'relate' to or feel some affinity with their human points of contact through the various services they interacted with. A sense of commonality and understanding was deemed a strong determinant of the level of success achieved in both drug & alcohol and mental health services. It appears that there is a direct correlation between caring and empathy, the building of a relationship, and the perceived quality of support received.

2. Housing – "Warehousing" people with similar problems together has a negative impact on recovery. It is more difficult to stop using drugs and alcohol and remain abstinent when surrounded by others who are using heavily. This in turn has a negative impact on mental health.

Another important factor that arose was the 'moving on' process. Many of our participants felt that they had been 'forgotten about' once placed in a hostel. With some reporting little or no structured support or advice around re-housing.

3, Access to Support - Many people felt that they didn't know about all the services they could access. They also spoke about the challenge of having to navigate help for different presenting needs and the difficulty of having to repeat their story every time they meet someone new.

Waiting times - There appeared to be a vast difference in the waiting times for initial contact with certain services. For instance the waiting time for an assessment for statutory Mental Health services was often felt to be overly long, whereas the waiting time for an assessment for drug or alcohol services was found to be short in comparison.

Formality of services - Participants felt that drug and alcohol services tended to be less formal which made access and engagement easier for them. Statutory mental health services on the other hand were thought to be too structured and formal. This meant people often felt more comfortable seeking help from drug & alcohol services.

Communication - Communication of information between services was felt to be poor. Service users found themselves repeating their stories over and over again across a range of services. Many found this frustrating and disheartening. The fact that there doesn't seem to be any central information hub or collection point for services users' information was a recurring theme in our research.

Peer Support - Almost every participant through the research spoke of the value of lived experience in the delivery of services.

4. Use of time -Participants who had stopped using drugs & alcohol and felt their mental health was stable spoke overwhelmingly about the importance of having something positive to do with their time.

5. Understanding dual diagnosis - Many participants had been passed from service to service until they found one that 'fits' their support needs. Instead people feel they require help for a set of problems that all impact on each other.

Recommendations

1. Statutory mental health services should consider how to become more effective at engaging those with dual diagnosis who are unable to access overly structured support. An example of this would be to provide in-reach to hostels and other homelessness services
2. Drug & alcohol and other mental health services should also be providing in-reach to hostels. This will help initiate contact for those requiring support
3. Staff in voluntary sector services should be enabled to understand how to engage people with dual diagnosis more effectively. This could be done through the provision of training and networking by statutory mental health services, which would also facilitate more effective joint working and information sharing
4. A better relational approach should be adopted by services offering support to people with dual diagnosis. A good working example of this is the Enabling Environment (EE) and Psychologically Informed Environment (PIE)
5. A single point of assessment and access to support for people with dual diagnosis
6. Lived experience should be incorporated into service delivery wherever possible. This could be done in several ways:
7. Employing more people with lived experience within services
8. Expanding the Recovery Club model to be used within more services
9. More peer delivered support services
10. More service user involvement in commissioning and designing of services

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Health and Wellbeing Board 29th September 2015	Tower Hamlets Health and Wellbeing Board
Report of: Tower Hamlets Clinical Commissioning Group	**Classification:** Unrestricted
Integrated Care in Tower Hamlets – Update	

Contact for information	Jane.Milligan@towerhamletsccg.nhs.uk

Executive Summary

The Integrated Care programme is a major piece of health and social care transformational work that aims to support those most at risk of being admitted to hospital. The programme aims to change the way that patients receive care and the way that their care is organised and administered, with a focus on care being more coordinated and tailored to the needs of the individual.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. NOTE the *Integrated Care in Tower Hamlets – Update* presentation.

1. DETAILS OF REPORT

1.1. This presentation has been developed to provide an overview of the Tower Hamlets Integrated Care programme to the Health and Wellbeing Board and summarise the partnership approach to commissioning and delivery.

The Integrated Care programme is a major piece of health and social care transformational work that aims to support those most at risk of being admitted to hospital. The programme aims to change the way that patients receive care and the way that their care is organised and administered, with a focus on care being more coordinated and tailored to the needs of the individual.

Appendices and background documents

Appendices

- NONE

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- NONE

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Tower Hamlets
Clinical Commissioning Group

Integrated Care Update

Jane Milligan, Chief Officer, Tower Hamlets CCG

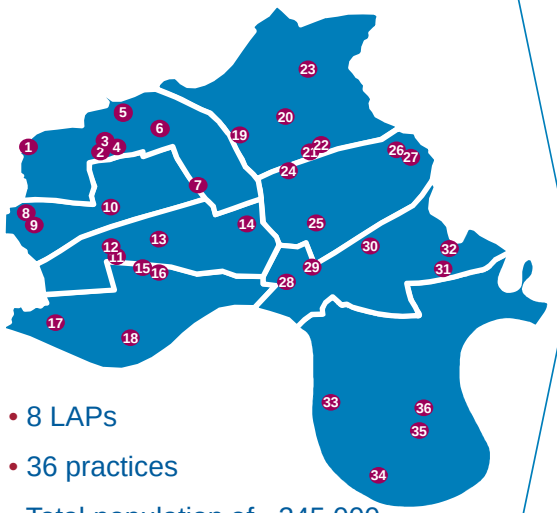
Dr Navina Evans, Director of Operations and Deputy CEO, East London NHS Foundation Trust

Karen Breen, Managing Director, The Royal London and Mile End Hospitals

29th September 2015

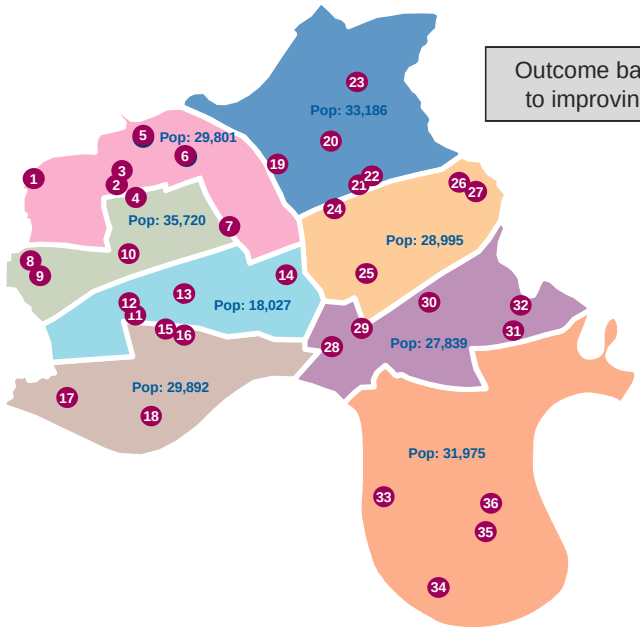
Primary Care Trust legacy: Primary care networks

Tower Hamlets before networks



- 8 LAPs
- 36 practices
- Total population of ~245,000
- Practice list sizes of 3,000 to 11,000

8 Networks[1] were formed in the borough during 2009



Outcome based contracts linked to improving population health

Why networks?

- Focus on **population health** across a geography
- Collaborative relationships with **wide range of partners** (e.g. Borough, schools, charities)
- Sufficient **scale for** specialisation of staff, ability to access rare skills and ensure access, resources (e.g. equipment)
- Integration with **estates** plan

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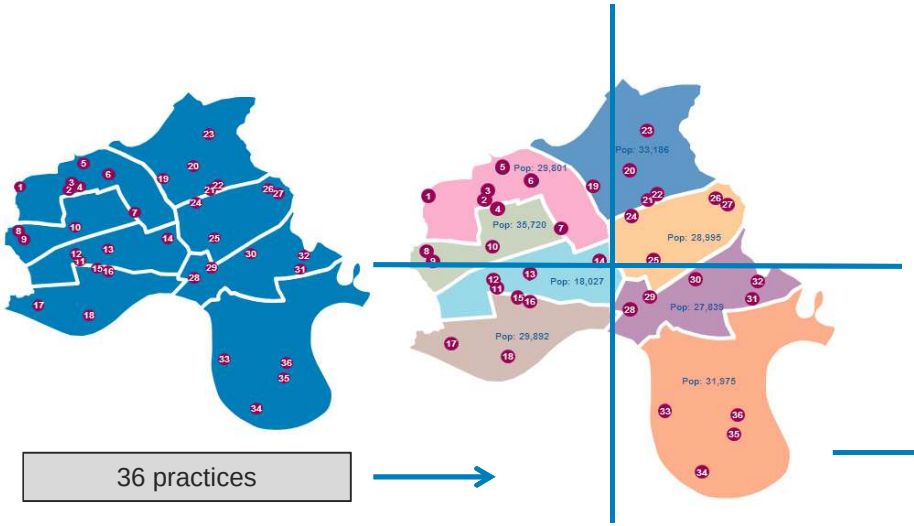
Creation of one provider



36 practices

8 networks

&

4 localities

Multidisciplinary Locality Integrated Care teams:

- Community nurses
- Mental health teams
- Outreach geriatricians
- Social workers

TOWER HAMLETS GP CARE GROUP CIC

LOCAL PEOPLE, LOCAL HEALTH

1 provider

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Integrated Care Programme

WELC Care Collaborative

We want to deliver at scale and pace to achieve radical transformation across WELC

By shaping the local health economy around the patient

- Using National Voices principles to embed patient-centred care focusing on patients needs and preferences
- Proactively manage people's care, responding rapidly to crises, avoiding emergency admissions and residential care where possible
- Ensuring most effective use of care resources and avoiding duplication

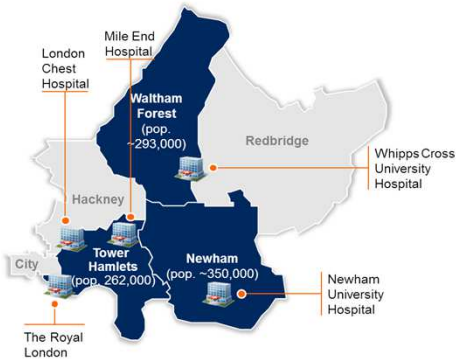
By changing behaviours across the system

- Supporting staff to work together across organisational boundaries
- Helping people to feel empowered and supporting self care
- Enabling people to stay socially active and live independently
- Aligning our commissioning intentions across health and social care

By developing the provider landscape

- Taking a whole system approach to change, using technology to deliver effective and timely care
- Aligning incentives and payment structures for providers to take ownership for system-wide outcomes
- Developing system wide performance measures and feedback mechanisms to support continuous improvement

NHS Waltham Forest Clinical Commissioning Group
UCLPartners Academic Health Science Partnership
North East London NHS Foundation Trust
Newham London
Waltham Forest
NHS Newham Clinical Commissioning Group
NHS Tower Hamlets Clinical Commissioning Group
East London NHS Foundation Trust
Barts Health NHS Trust
TOWER HAMLETS



NHS Tower Hamlets Clinical Commissioning Group

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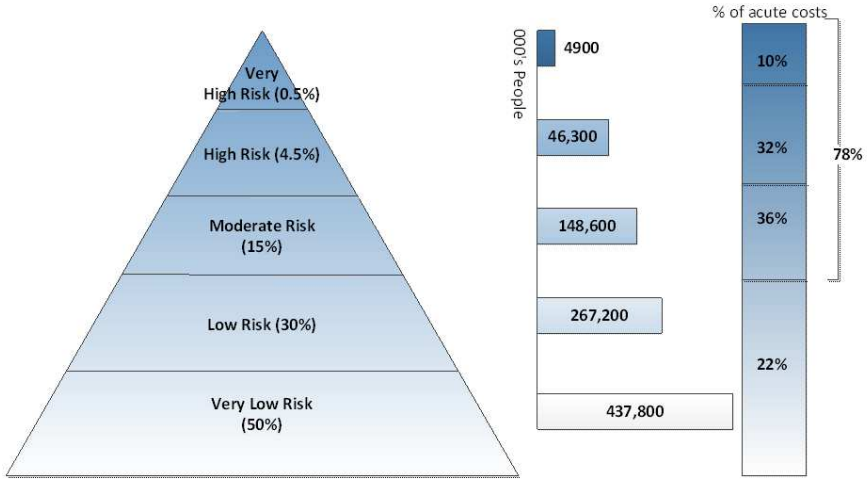
Key building blocks of the programme

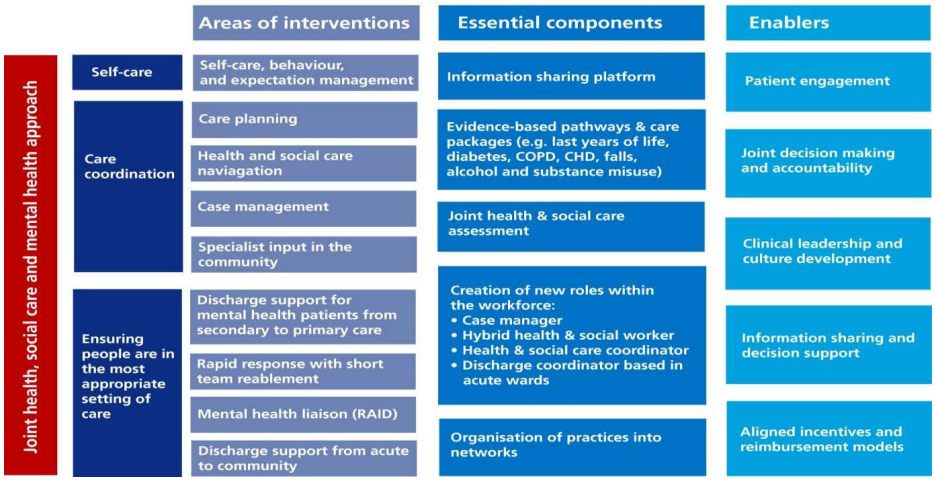
Who are we targeting for integrated care ?



Using risk stratification to proactively identify 20% of population most at risk of a hospital admission and commission some/all of services below for this group

Commissioners moving to focus on outcomes for population health, new models of care (the integration function/provider alliances) and reforming financial incentives (capitation and payment on outcomes)

WELC will provide nine key interventions for its population underpinned by five components and enablers



The Integration Function

- Developed in 2013/14 as a way of assuring the CCG that providers are able to work together in delivery of integrated care

- Arranged around a number of key principles:

- Clinical governance and shared standard operating procedures
- Clear joint work on operations, pathways, SOPs and resilience
- Joint communications and engagement
- High quality and shared data and reporting
- Development of shared care record

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Tower Hamlets Integrated Provider Partnership (THIPP)

Tower Hamlets Integrated Provider Partnership (THIPP)

GP CARE GROUP CIC · TOWER HAMLETS · NHS

Barts Health NHS Trust
East London NHS Foundation Trust

Four partners




Partners came together in 2013 initiated by the CCG to develop the integrator function
THGPCG Care Group - Primary care
Barts Health – Community Services and Acute Care
East London Foundation Trust – Acute Mental Health
London Borough of Tower Hamlets - Social Care & Public Health
Work underway to develop further links with housing, education and third sector through the development of a Stakeholder Council and wider partnerships.

One vision

- To work together in a partnership that delivers innovative, integrated and seamless care to patients, carers and their families
- Care will be patient focused, co-ordinated and will make a real positive difference to users that receive it
- Appropriate services will be provided in the right way, in the right place and at the right time
- Provide services in the homes of patients and service users (when possible) and in community, hospital or other locations (when necessary)

Partnership delivery

- Community based specialist support
- Integrated health and social care teams
- Existing examples of good partnership working
- Strong desire for quality improvement
- Commitment to the WEL Integrated Care programme

Developed programmes of work

- THIPP awarded Vanguard status to progress the established programme of work to deliver integration / deliver new models of care for the residents of Tower Hamlets
- THIPP collectively bidding to run Tower Hamlets Community Health Services
- THGPCG successful in Prime Ministers Challenge Fund to improve primary care access

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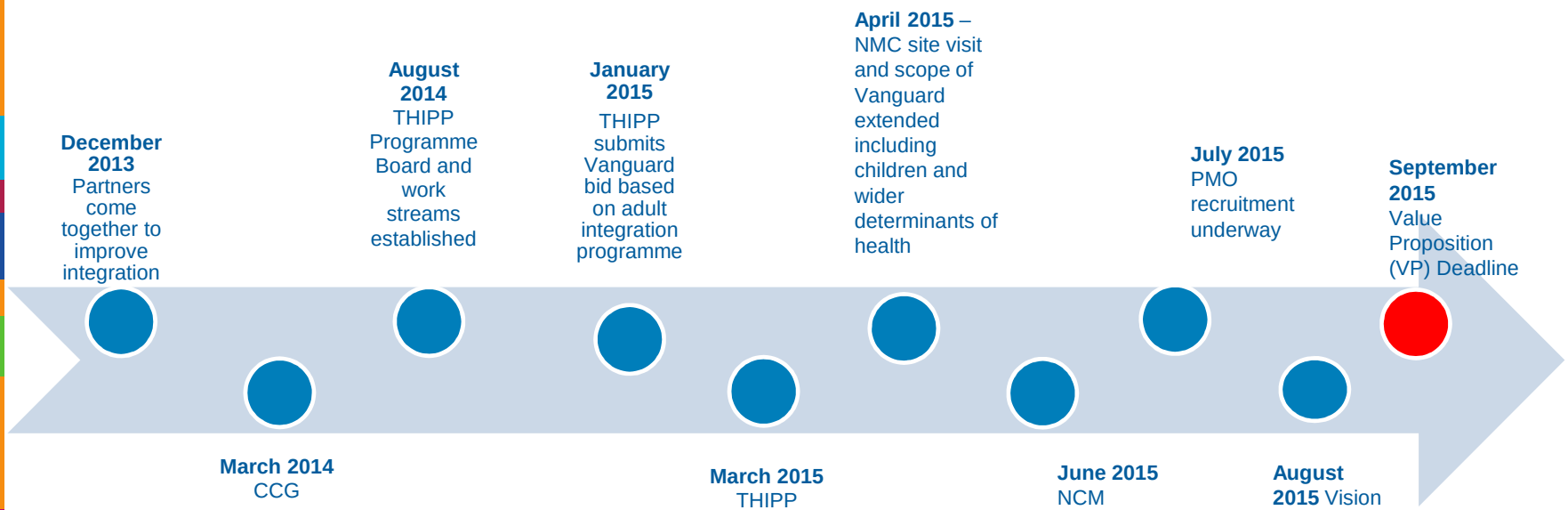
THIPP journey so far…



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Outcomes and incentives

Components of the integrated care capitated budget

Payment design features

- A per capita amount for a defined population and agreed level of care -'scope and scale'
- Gain/loss sharing mechanisms
- Payment for outcomes mechanisms
- The contractual framework

Implementation infrastructure

- Provider partnerships
- Finance and quality data collection and reporting
- Finance and payments- contract monitoring

5

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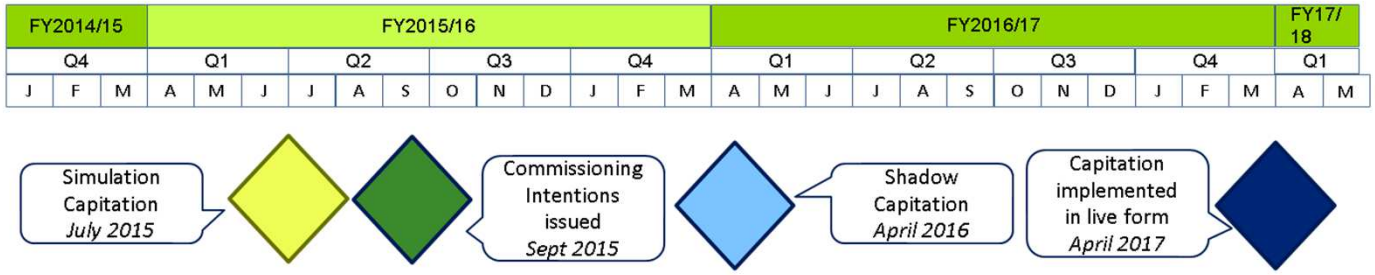
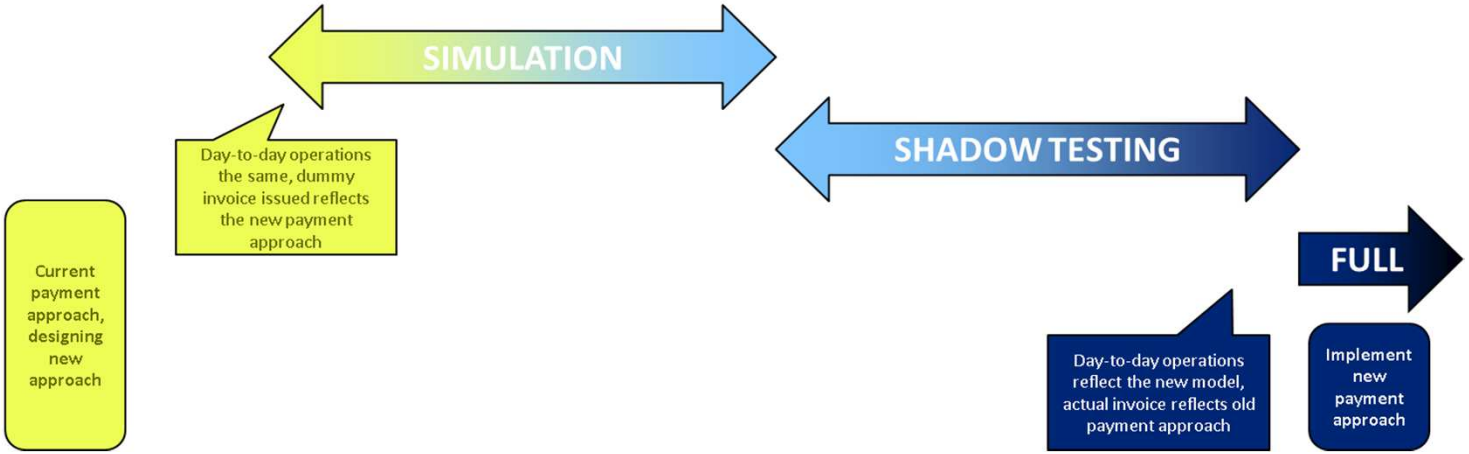
Clinical Commissioning Group

Timescales

WELC timescale for implementing capitation



What do we mean by shadow testing?



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Thank you

Questions?

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Health and Wellbeing Board 29th September 2015	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
A prevention-orientated system	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Abigail Knight, Acting Associate Director of Public Health
Executive Key Decision?	No

Summary

1.1 Making Every Contact Count (MECC) is a national programme allowing for locally tailored delivery. It provides an important opportunity to embed prevention in all frontline services. This paper sets out the current stage of development across local authority services, primary care, Barts Health and East London Foundation Trust. It also sets out the proposed areas of development: embedding MECC principles in all service pathways, aligning to the social prescribing programme and achieving economies of scale through delivery across a wider geographic footprint.

1.2 The full report is attached.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. note progress on the Making Every Contact Count (MECC) programme
2. comment on the proposed areas for further development

1. REASONS FOR THE DECISIONS

1.1 Making Every Contact Count provides a key opportunity to embed prevention within system delivery. There are identified benefits to developing a unified approach across the Health and Wellbeing partnership.

2. ALTERNATIVE OPTIONS

2.1 This paper presents the current approach to Making Every Contact Count within each sector of the health and wellbeing economy.

3. DETAILS OF REPORT

3.1 The report is attached.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The work being carried out in respect to MECC is met from public health grant, there are no direct financial implications as a result of the recommendations in this report.

5. LEGAL COMMENTS

5.1 The report updates the HWBB about the progress of the making every count programme. The MECC programme is supported through an implementation guide and national toolkit published by the NHS.

5.2 The MECC has no statutory basis however following the public health agenda being formally transfer to the Council in April 2013 it provides a framework within which public health is able to use the opportunities of a local government setting to improve health and wellbeing.

5.3 The MECC programme contributes to the Council meeting its general duties under the Care Act 2014 (the Act), which include –

- To promote an individual's well-being. Well-being is defined in the Act and includes control by the individual over day-to-day life. In exercising this general duty the Council must have regard to the importance of preventing or delaying the development of needs for care and support as well as and the importance of the individual participating as fully as possible.
- To promote integration of care and support. The statutory guidance supporting the Act includes guidance for Council departments working more closely together and in a joined up manner.
- To establish and maintain a service for providing people in its area with information and advice relating to care and support. This service should include information about the choices and types of care and support available, choices of providers available and how to access the care and support.
- To promote diversity and quality in the provision of services within the locality. Under this section the Council must ensure that commissioning and

procurement practices deliver the services that meet the requirements of the Act.

5.4 The Care and Support Statutory Guidance (2014) supporting the Act is clear that information and advice is fundamental to enabling people, carers and families to take control of, and make well informed, choices about their care and support. In arranging the provision of advice and assistance the Council is encouraged to take an active and critical role in arranging the delivery of advice. The statutory guidance explains that this requires the Council to work across its area to ensure coherence, sufficiency and accessibility of the information and advice. In doing this the statutory guidance recognises that the role of the Council will be to understand, co-ordinate and make effective use of resources available to people in its area.

5.5 The recommendations to note the content of the MECC report and comment on the proposed areas for further development are within the terms of reference of the HWB, in particular:

i) To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
ii) To consider and promote engagement from wider stakeholders.
iii) To have oversight of the quality, safety, and performance mechanisms operated by member organisations of the Board, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health. Areas of focus to be agreed from time to time by members of the Board as part of work planning for the Board.

5.6 When considering the recommendation regard must be given to the public sector equalities duty to eliminate unlawful conduct under the Equality Act 2010. The duty is set out at Section 149 of the 2010 Act. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 Making Every Contact Count provides an important opportunity to address health inequalities within Tower Hamlets.

7. BEST VALUE (BV) IMPLICATIONS

7.1 The principles behind Making Every Contact Count involve maximising the effectiveness of existing frontline resource by embedding prevention within

practice. The proposals for further development of the programme include consideration of achieving economies of scale.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 Limited relevance

9. RISK MANAGEMENT IMPLICATIONS

9.1 This risks to the council are minimal. This sets out an approach to organisational development across the health and wellbeing partnership.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 Limited relevance

Linked Reports, Appendices and Background Documents

A Prevention-orientated system

Abigail Knight, Acting Associate Director in Public Health
September 2015

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1. Purpose
The Health and Wellbeing Board is asked to note progress on the Making Every Contact Count (MECC) programme and comment on its proposed areas of further development.

2. Background
MECC is a public health initiative which aims to encourage those who work with the public to make the most of every opportunity to have a conversation about a healthy lifestyle and offer signposting information to facilitate behaviour change. This is part of the national programme of the same name, with a locally tailored approach to training and prevention approaches. Frontline staff receive training in how to pick up on conversational cues about healthy lifestyles that someone may be willing to discuss, and how to encourage them to take action. This is not about telling people what to do, nor what not to do. It is about helping people to identify for themselves where they would benefit from some support.

MECC is built on a broad evidence base (NICE, Public Health Guidance on behaviour change approaches 2014) that brief advice and signposting to services, when delivered on a large enough scale, can deliver behaviour change within a population. This in turn leads to improvements in the health of individuals and reductions in the numbers preventable diseases in communities. MECC is also recognised for its contribution to improving employee health and wellbeing.

3. Implementation
The London Borough of Tower Hamlets public health team has developed a localised training programme and accompanying training material. This training programme is being delivered to a range of staff across the wider partnership in the borough to ensure we have

consistency of message in the brief advice and signposting offered. We are also working with teams as to how we can embed this in practice thus ensuring it is part of business as usual.

The learning outcomes of the Tower Hamlets' MECC training programme are:

- *To improve knowledge about key public health messages: smoking, alcohol, healthy eating, physical activity and mental health.*
- *To build on existing skills in promoting healthy lifestyle and behaviour change*
- *To explore and identify opportunities to raise key health issues*
- *To recognise opportunities for staff and staff team to put MECC into practice*

3a. Adults and Children's Services
In 2015/16 we are working with both Adults and Children's Services to build MECC into the corporate training programme. This follows a successful six month pilot in the previous year.

In the initial phase of this pilot, MECC was introduced to service directors and managers to support the development of a generic workshop appropriate for all frontline staff across Adults and Children's Services. The resulting coproduced workshops were delivered to 200 staff. The service groups who have received this training are set out below:

Service	**Number of staff**	**Number of participants**
First Response Team	58	23
Reablement Team	60	26
Resources Team (Day Care Centre staff)	50 (approx.)	17
Community Learning Disabilities Service	60	41
Occupational Therapy	25	21
Children's Social Care teams	85	60
Service users liaison team LBTH	13	13

In response to the Care Act, the London Borough of Tower Hamlets has introduced Framework I assessments, which are to be administered by all frontline health and social care staff who are in contact with local residents. This assessment includes a question on MECC to act as a prompt for staff. It enables us to identify when brief advice on smoking cessation, alcohol, mental wellbeing, healthy eating, physical activity or sexual health is given, and to which support service someone has been signposted. Through this mechanism we intend to monitor the level of MECC activity at regular intervals, and to provide targeted support where needed.

3b. Wider local authority and voluntary sector services
In 15/16 the MECC programme is being expanded to offer training to staff from a wider range of services. To date we have secured the involvement of the following teams:

- Drugs and Alcohol Action Team
- LinkAge Plus
- Idea Stores
- Tower Hamlets Homes
- Providence Row Housing
- Poplar Harca housing association
- Emergency services
- Care homes

- Salvation Army
- Mental health support service providers

3c. Primary Care
Public Health successfully bid for a workforce development grant from the Health Education North Central and East London. The £16K grant will support training and development in the wider health workforce, in alignment with strategic priorities for the sector. It enables the MECC training programme to be delivered, from October 2015, to 400 frontline staff working within different settings of care, including acute services, community services, primary care services, mental health service, social care service, pharmacy and voluntary and independent sector organisations.

3d. Barts Health
Barts Health has well developed programmes providing opportunistic health promotion amongst patients. The most advanced is smoking cessation which includes online training, advertising throughout the trust and an electronic referral system with rapid feedback to clinical areas. A key area of intervention is at Pre-operative Assessment. This year Barts Health aims to refer at least 2,500 patients, introduce CO monitoring in maternity and launch a new Tobacco policy that will support staff in challenging smokers on Trust grounds and offer support and referral to stop smoking services.

Barts Health are introducing formal screening of patients attending all its A&Es for dangerous levels of alcohol use, using the NICE approved screening tool and improving information giving, provision of IBA (Identification and Brief Advice) and onward referral to community alcohol services where appropriate.

Barts Health works with colleagues, such as diabetes clinicians, to contribute to prevention. They run a number of successful programmes, such as opportunistically identifying patients with HIV and other viruses including hepatitis, who attend as emergencies and save lives by instigating earlier treatment.

3e. East London NHS Foundation Trust (ELFT)
ELFT runs a Trust-wide Quality Improvement Programme, within which there is a physical health collaborative. This aims to address parity of esteem by improving the physical health of people with serious mental illness. ELFT is adopting a quality improvement approach to health promotion in which small scale interventions, such as information and signposting to lifestyle services, are monitored and reviewed by the staff delivering them and suggestions for improvements are led by staff. Training to staff in this quality improvement approach is made available through the wider programme at ELFT.

4. Evaluation of the pilot programme
Early findings from the evaluation of MECC show that participants have increased confidence and skills in raising health messages. Post training follow-up sessions with participants revealed a number of positive case studies of putting MECC learning into practice.

- 92% of participants felt that it was important to promote health with clients when the opportunity arises
- As a result of the training 89% of participants felt more confident in raising lifestyle issues with clients
- As a result of the workshop 83% of participants felt better skilled to help clients to make lifestyle changes
- As a result of the workshop 82% of clients felt more confident to signpost clients appropriately to support services

What did participants find most useful about the workshop? *"New ways to interact with clients"* *"The right words to say to the clients"* *"Ways to get discussion started"* *"Ways to address health and other issues with families in a non-confrontational manner"* *"Practical aspect - putting it into practice in a safe environment"* *"How to raise the issue"* *"Training was highly relevant to my role. I have learned about reflective listening and how to motivate clients"* *"The importance of expressing empathy – looking through someone else's glasses"* *"Really listening to what people are saying, reflecting that"* *"Made me think about my approach – probably coercive / persuasive!"* *"Making me stop and think before speaking"* *"Signpost information to local health services information"* *"Listen and reflect. Let client lead where necessary"*
What will participants take away about MECC? *"Health promotion is everyone's business"* *"It only takes a few minutes to make a contact count"* *"Promoting health is vital in our work with service users"* *"Make every contact count. Even if it's a 5 minute conversation - it can make a difference"* *"Importance of promoting positive health messages when service users are open to this"* *"That it's worth raising a subject with someone when you have the opportunity"* *"The government statistics and facts"* *"Understanding what healthy eating is"* *"Per 100g guidelines"* *"Seeing the alcohol glasses to understand units….seeing the food plate to understand portion size and a balanced diet"*

Additional feedback showed:

- Participants valued the opportunity to reflect on their practice of supporting clients and improving their own health.
- Participants expressed that they would like further refresher training to reinforce what they learnt.
- Some participants were interested in attending a more in depth training to support clients they saw frequently – a motivational interviewing 2 day training course. Occupational Therapy staff expressed a particular interest in this training.

5. Proposed areas of development

5.1 Embed MECC in all service pathways

The inclusion of MECC in the Framework I assessment, is an example of good practice that allows MECC to both be embedded in practice and its implementation monitored. The MECC training programme is one aspect of service delivery and as it is rolled out to new service areas, we need to identify other opportunities to ensure it results in staff delivering brief advice and signposting opportunities.

5.2 Alignment with the Social Prescribing Programme
Tower Hamlets CCG is currently developing its specification for implementing social prescribing across the borough, following a pilot in the north east of the borough. This programme is intended to identify needs and priorities in people attending primary care that lie outside of the medical model, and provide signposting to the appropriate support or services for them. There are obvious parallels with MECC: the skills required to offer brief advice and signposting, ensuring there is a means of embedding this in practice, and the types of service to which people may be signposted. We therefore propose to align the approach taken in MECC and social prescribing.

5.3 Delivery across the WELC footprint
The WELC boroughs (Tower Hamlets, Newham and Waltham Forest) are all at different stages in their development of MECC and social prescribing. There is an opportunity, through the Transforming Services Together (TST) programme, to better enable consistency of message across these boroughs by working collaboratively on these programmes. The greatest opportunities that this presents are: unified approach to workforce development, sharing best practice in embedding MECC into practice, and a single evaluation that allows comparison of the different approached that have been adopted.

6. Conclusion
Each sector of the health and wellbeing economy is developing MECC, or similar programmes to support a prevention orientated system. There are further opportunities to work together in its development towards:

- Consistency of advice
- Shared training programmes
- Adopting a systems approach to embedding training in practice
- Economies of scale across a wider geographic footprint
- Engagement at all levels, from senior to front-line staff.

In the context of the Health and Wellbeing Strategy refresh we may want to explore these opportunities further.

Health and Wellbeing Board 29th September 2015	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Housing and the integrated care agenda	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Tim Madelin, Senior Public Health Strategist, LBTH Sarah Castro, Programme Manager, Polar HARCA
Executive Key Decision?	No

1 Executive Summary

1.1. The aim of integrated care is to deliver co-ordinated and person-centred care supporting and empowering patients to self-care and self-manage. There are currently 9143 involved in the programme and this will increase in future years. Information sharing between providers involved in integrated care is seen as essential for the success of the programme.

1.2. Registered social housing providers (RPs) provide about 40% of the dwellings in the borough and house many of the most vulnerable residents in the borough who will include many of those involve with integrated care. Tower Hamlets Housing Forum (THHF) is a partnership of RPs in the borough and they have recently decided to set up a health sub-group to more consistently address health issues.

1.3. Initial consultation with the THHF community involvement forum has highlighted that there are some issues to be addressed if the opportunities for greater collaborative working are to be realised.

1.4. The purpose of the case study is to examine the opportunities for greater joint/integrated working between the social housing and health care sector and the potential beneficial outcomes this can have for residents.

2 Recommendations:

The Health and Wellbeing Board is recommended to:

1. Consider the case study being presented highlighting the opportunities for greater integrated working between health care providers and registered housing providers and discuss potential actions to take these opportunities forward and address barriers.

1. REASONS FOR THE DECISIONS

1.1. Case study presented for discussion

2. ALTERNATIVE OPTIONS

2.1. Not applicable - Case study presented for discussion

3. DETAILS OF REPORT

Integrated care – moving beyond traditional settings

3.1. The aim of integrated care is to deliver co-ordinated and person-centred care supporting and empowering patients to self-care and self-manage. People with high levels of health activation, with the knowledge, skills, and confidence to manage their health, are more likely to adopt healthy behaviours, have better clinical outcomes and lower rates of hospitalisation. Levels of activation can improve when a person-centred approach is followed and people are supported to develop a sense of ownership and control over their health and are empowered to make informed choices.

3.2. The target population for Integrated Care over the next 3-5 years is the same for all providers and is identified as patients who have very high risk, high risk or moderate risk of a hospital admission in the next 12 months and have consented to participate in the programme. Over the year 2015-16, the target population for the Integrated Care programme in Tower Hamlets will be the top 6% of the population who is at risk of admission borough-wide.

3.3. Grouping the population based on needs, is an approach used by many Integrated Care Programmes across the country. Risk stratification is a term often used for dividing the population based on the risk for an emergency admission. Although a tool is used to calculate the risk decisions about which patients should receive the interventions of the Integrated Care Programme are also be based on a detailed assessment of the patients` needs taking into account individuals` perspectives and incorporating clinical judgement.

3.4. At end of March 2015, integrated care was focussed on the highest risk 4% of the population a total of 9143 people. Of these people enrolled on the pathway 7117 had a crisis plan and 1558 had a crisis and personalised care plan.

3.5. The component services within the programme are being delivered by a range of staff types and grades across a number of providers in a wide number of locations including patients' own homes. Rapid response and discharge support services within the community and the hospital, the community geriatrician role, the homeless care pathway, community care navigators and

close working with social care services are examples of integrated care initiatives across providers in Tower Hamlets.

3.6. Information sharing between providers is critical to successful integration and providers should be working towards safe, secure and efficient mechanisms to share relevant data across organisational boundaries with patients` consent.

3.7. There is however an opportunity for strengthening communication and joint working between health, social care and social housing providers to improve the care that people receive on the pathway.

3.8. Going forward there will be a greater emphasis on integrated care increasingly delivered outside traditional health care settings. There are already a number of initiatives such as the Vanguard pilot that will lead to an expansion of the numbers of people subject to integrated care in the borough.

Social Housing and Integrated Care – challenges and opportunities

3.9. Social housing providers provide nearly 40% of the dwellings in the borough and house many of the most vulnerable residents in the borough including those in the identified high risk groups. 12,000 are managed byTHHF which is the council's Arms Length Management Organisation (ALMO) and remaining 29,000 by RPs. Their staff (including housing officers and caretakers) are in regular contact with many of these residents.

3.10. THHF is the structure in which RPs come together in the borough. The group considers health issues and more recently agreed to set up a more formal health sub-group. This will help ensure that smaller RPs are also included and that they all give consistent messages to their residents around health

3.11. The commitment from both housing and health is strong with a joint desire to solve problems/issues on behalf of residents/clients. An initial housing and health action plan was developed by THHF and the HWB in February 2014. The action plan featured joint activities aligned to the health and wellbeing strategy's priorities.

3.12. Key actions in the joint housing and health action plan include:

- A RP compact on mental health and supporting vulnerable tenants, developed in partnership with the CCG (completed March 2015);
- sharing of best practice on fostering healthy living in communities, supported by Public Health (ongoing);
- tackling accidents involving children within the home, supported by Public Health (ongoing).

3.13. Public Health has a long working relationship with RPs and delivered a number of initiatives in partnership utilising community development approaches to promoting health e.g. Well London initiatives with Poplar HARCA and Tower Hamlets Community Housing

3.14. The recent community involvement network meeting (RP staff involved in community involvement) considered current barriers, blockages and challenges to closely working between housing and health care sectors:

- Difficulty navigating the health and social care sector to highlight issues and opportunities from an RP perspective
- A need for the opportunities to develop work together around health and housing to be more clearly recognised and prioritised
- Set of challenges in taking forward opportunities relating to
    - Employee turnover
    - Changing health and social care landscape
    - Consistent communication and messaging across agencies
    - Ongoing consistent ownership of joint work
    - Tracking outcomes of initiatives

3.15. The recent community involvement network meeting also considered how the two sectors could work better together and produced the following thoughts;

- RPs are one of the main contact organisations for many residents and there is therefore significant opportunity to provide consistent information and guidance on health and social care issues as well as feedback to service provider
- Some residents do not make as much use of primary care as they could to support their health - there is an opportunity for housing staff to support residents on issues such as GP registration and use of services
- RP websites could be a valuable resource for conveying consistent information on health and healthcare services as well as information for events
- Common tools could be developed to measure the impact of health and housing initiatives could be developed to use across the THHF partnership.
- Greater involvement of RPs on relevant health and social care boards would be helpful to provide the collective leadership to tackle barriers and ensure a realistic pace that is mindful of the need to build relationships at all levels of the organisations.

Next steps – Board discussion

3.16. A case study (fictionalised but based on typical issues) will be presented at the board to explore the opportunities for greater joint working between healthcare and housing providers and how these could be taken forward.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. The work to explore opportunities for more integrated working will need to consider how any additional workstreams which are created will be funded.

5. LEGAL COMMENTS

5.1. The report identifies an opportunity for greater joint/integrated working between the social housing and health care sector and the potential beneficial outcomes this can have for residents.

5.2. The identification of the opportunities may contribute to the Council meeting its general duties under the Care Act 2014 (the Act), which include –

- To promote an individual's well-being. Well-being is defined in the Act and includes control by the individual over day-to-day life. In exercising this general duty the Council must have regard to the importance of preventing or delaying the development of needs for care and support as well as and the importance of the individual participating as fully as possible.
- To promote integration of care and support with health services. The statutory guidance supporting the Act includes guidance for Council departments and their partners working more closely together and in a joined up manner.
- For the Council and its partners to co-operate generally in the exercise of the respective functions which includes, for example, a private registered provider of social housing.
- To establish and maintain a service for providing people in its area with information and advice relating to care and support. This service should include information about the choices and types of care and support available, choices of providers available and how to access the care and support.
- To promote diversity and quality in the provision of services within the locality. Under this section the Council must ensure that commissioning and procurement practices deliver the services that meet the requirements of the Act.

5.3. Whilst independent living is not specifically mentioned within the definition of wellbeing in the Act the statutory guidance recognises that the concept is a core part of the wellbeing principle.

5.4. The Council has broad powers to provide different types of accommodation in order to meet people's needs for care and support. The Act is clear that suitable accommodation can be one way of meeting care and supports needs. However, the Act is also clear on the limits of responsibilities and relationship between care and support and housing legislation, to ensure that there is no overlap or confusion. Section 23 of the Act clarifies the existing boundary in law between care and support relevant housing legislation, such as the Housing Act 1996. Where the Council is required to meet accommodation related needs under housing legislation as set out in the Housing Act 1996 or under any other legislation specified in regulations then the Council must meet those needs under that housing legislation.

5.5. The Health and Social Care Act 2012 ("the 2012 Act") makes it a requirement for the Council to establish a Health and Wellbeing Board ("HWB"). S.195 of the 2012 Act requires the HWB to encourage persons who arrange for the provision of any health or social care services in their area to work in an integrated manner. The exploration of the options above may assist with this requirement on the Council.

5.6. Any change in provision or services should be considered in accordance with the public sector equalities duty to eliminate unlawful conduct under the Equalities Act 2010. The duty is set out at Section 149 of the Equality Act 2010. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 Improving integrated working between health and housing will provide a basis for addressing the health needs of the most vulnerable groups in the population

7. BEST VALUE (BV) IMPLICATIONS

7.1 [Please use this paragraph to set out the Best Value implications of the report's proposals; this is a requirement of the Council's BV Action Plan. Please see the relevant guidance for report authors.]

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1. Not applicable - Case study presented for discussion

9. RISK MANAGEMENT IMPLICATIONS

9.1. Not applicable - Case study presented for discussion

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1. Not applicable - Case study presented for discussion

11. EFFICIENCY STATEMENT

10.1 More integrated working may increase efficiency through reduction of duplication and earlier intervention.

Appendices and Background Documents

Appendices

- None

Background Documents

- None

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Health and Wellbeing Board 29th September 2015	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Health and Wellbeing Strategy Refresh	

Lead Officer	Melanie Clay, Corporate Director Law, Probity and Governance
Contact Officers	Louise Russell, Service Head for Corporate Strategy and Equality
Executive Key Decision?	No

Summary

This report outlines the approach that will be taken to develop the refreshed Tower Hamlets Health and Wellbeing Strategy. All Health and Wellbeing Boards have a duty to publish and deliver local health and wellbeing strategies. This strategy will be developed through a partnership approach, consulted on, presented to the CCG Board, HWB and endorsed by the Council's Cabinet.

Formal approval of the Health and Wellbeing Strategy and its delivery plans will be sought in July 2016. Once approval has been given, the Strategy will then be published.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Agree the timeframe for the refresh of the Joint Health and Wellbeing Strategy
2. Note that a priority setting workshop for HWB members is planned for November.

1. REASONS FOR THE DECISIONS

1.1 The Joint Health and Wellbeing Strategy is due a refresh as the existing strategy comes to an end in 2015. The HWB is asked to agree the refresh timeline for the new strategy.

2. ALTERNATIVE OPTIONS

2.1 An alternative timeframe for the refresh of the Joint Health and Wellbeing Strategy can be developed. Consequently, the Strategy could be brought forward or delayed, depending on the Board's decision. If delayed, the current strategy and it's delivery plans can be extended.

3. DETAILS OF REPORT

Introduction

3.1 The Health and Wellbeing Strategy 2013-16 and its associated delivery plans are required to be reviewed and refreshed to be ready for delivery between 2016/19. The Health and Wellbeing Strategy will be built on a firm evidence base; with the Joint Strategic Needs Assessment at the centre of this. Data from the Community Plan/Medium Term Financial Plan consultation will also be utilised.

3.2 The development of the Health and Wellbeing Strategy will start with a seminar and forward looking workshop for key stakeholder organisations and HWB members. The seminar and workshop will be facilitated by the Corporate Strategy and Equality team, the LGA and the King's Fund respectively. There will be a need for constant dialogue with the Board, the CCG, key stakeholders and Council committees. The Health and Wellbeing Strategy subgroup will act as the project board for the refreshing of the Health and Wellbeing Strategy with regular reports provided at the Executive Officer Group and HWB.

Health and Wellbeing Strategy Workshop

3.3 A workshop, facilitated by the Local Government Association, is planned for November 2015. It will look at future trends in the local health and social care landscape; our current strategy priorities and how they align with any anticipated future changes in local health needs. This workshop will allow HWB members to evaluate delivery against the current strategy priorities and steer the development of the new priorities in the refreshed HWS.

Strategy refresh timeline

3.4 The project outline for the refresh of the Health and Wellbeing Strategy is below. The Council's Corporate Strategy and Equality team and Public Health will be leading on the development of the Strategy. The final draft of the refreshed Health and Wellbeing Strategy will be presented to the HWB in July 2016.

Strategy Development	Activity	Timescale
Scoping and reviewing	Development of a communication and engagement plan for the Strategy Refresh	September
	Engagement with key stakeholders on their current priorities and strategies (CCG, CVS, and Healthwatch etc.)	September - October
	HWB Workshop – Supporting board members to develop thinking/priorities for the Health and Wellbeing Strategy (local input through elected members) • An opportunity for HWB members to review the existing strategy's priorities and outcomes • Presentation of the EOG's King's Fund session outcomes • Board members to agree draft priorities Workshop attendees: all HWB members	November
Framework and emerging priorities	Priority mapping	September - October
	Seminar on future health and social care trends	October
	Gap analysis of stakeholder strategies and priorities	September - October
	Resident engagement programme to capture their views on health and their priorities	September – October
	Review of needs analysis and other material	September - October
	Draft framework and emerging priorities papers taken to the HWS subgroup	October
	Consultation on the draft framework with stakeholders, residents, Healthwatch and the Community Plan Delivery Groups	October/November
	Amended framework and emerging priorities paper taken to the HWS subgroup	November

	Framework and emerging priorities paper taken to the HWB	November
Priority development	Templates completed by sub-group on agreement of the new priorities	November
	Engage community plan delivery groups on the wider social determinants of health	November - January
Outline strategy and measures	Development of outcome measures	November - January
	Equalities Analyses	January
	Draft HWB Strategy taken to the HWS subgroup	January
	Consultation on the draft HWB Strategy	January – February
	Draft HWB Strategy taken to CMT/MAB	February
Delivery Planning	Workshops around priority delivery plans (using the logic model to develop activities)	March
	Delivery focused workshops with local community – Healthwatch, CVS and other groups	March - April
	Delivery plan templates completed by priority leads	April – May
	Draft delivery plans taken to the Subgroup	May
	Draft delivery plans taken to CMT/MAB	May – June
Finalising Strategy and Delivery Plan	Final draft considered by MAB/CMT/Cabinet	June – July
	Final draft considered by CCG Governing Body	June – July
	Final draft considered by HWB	July
	Launch	July

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The work to refresh the strategy is being funded through existing resources within the Corporate Strategy & Equality team. London Councils have provided a grant of £7k for the workshop facilitated by the Kings Fund, the workshop facilitated by the LGA is directly funded by the Department of Health.

5. LEGAL COMMENTS

5.1 The Health and Social Care Act 2012 ("the 2012 Act") makes it a requirement for the Council to establish a Health and Wellbeing Board ("HWB"). S.195 of the 2012 Act requires the HWB to encourage those who arrange for the provision of any health or social care services in their area to work in an integrated manner.

5.2 This duty is reflected in the Council's constitutional arrangements for the HWB which states it is a function of the HWB to have oversight of the quality, safety, and performance mechanisms operated by its member organisations, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health.

5.3 Section 116A of the Local Government and Public Involvement in Health Act 2007 places a duty on the HWB to prepare and refresh a joint strategic health and wellbeing strategy in respect of the needs identified in the Joint Strategic Needs Assessment, so that future commissioning/policy decisions are based on evidence. The duty to prepare this plan falls on local authorities and the Clinical Commissioning Group, but must be discharged by the HWB.

5.4 In preparing this strategy, the HWB must have regard to whether these needs could better be met under s75 of the National Health Service Act 2006. Further, the Board must have regard to the Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies published on 26 March 2013, and can only depart from this with good reason.

5.5 The review of the strategy provides the opportunity to refresh and update the focus of the HWB to reflect current and future needs within the borough. This review programme provides the basis for the HWB to collate the perspectives of all relevant and interested parties before agreeing any final strategy and plan.

5.6 When considering the recommendation above, and during the review itself, regard must be given to the public sector equalities duty to eliminate unlawful conduct under the Equality Act 2010. The duty is set out at Section 149 of the 2010 Act. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 An equalities assurance exercise and (if necessary) an equalities analysis will be undertaken as part of the strategy development and will cover all of the 9 protected characteristics. The Health and Wellbeing Strategy aims to address any health related inequalities and need within the Borough.

7. BEST VALUE (BV) IMPLICATIONS

7.1 The Health and Wellbeing Strategy sets out the local health and social priorities for Tower hamlets. The Council will secure economy, efficiency and effectiveness in the course of its contributions to the actions which deliver this

strategy. These actions will be set out in the Strategy's accompanying delivery plans.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There is a wealth of evidence, most recently compiled and presented within the Marmot review of health inequalities, identifying the considerable impact on health of wider social, economic and environmental impact on health, in particular housing, educational attainment, employment and the physical environment. These will be addressed as wider determinants of health within the Health and Wellbeing Strategy.

9. RISK MANAGEMENT IMPLICATIONS

9.1 The Tower Hamlets Health and Wellbeing Strategy is, by its nature, extremely broad. Its success depends on a range of enablers which are considered within the Strategy.

9.2 Delivery planning and performance management arrangements will be put in place to ensure delivery of the strategy. The Health and Wellbeing Strategy Sub-Group, which is formed of representatives from partners on the Board, including Healthwatch and voluntary sector representatives, will be key to driving the strategy centrally, as will the groups and leads driving and reporting on each of the four priority areas. The Health and Wellbeing Board will need to play a pivotal role in ensuring that outcomes are met and that challenges are raised where necessary.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 Health issues, in particular in relation to mental health, alcohol and drugs misuse have a significant impact on crime and disorder. The Health and Wellbeing Strategy will identify key opportunities to work with partners and the Crime and Disorder Partnership, including around substance misuse, domestic abuse and the health needs of (offenders/ex-offenders) sex workers.

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Linked Reports, Appendices and Background Documents
Linked Report

- None

Appendices

- None

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- None

Officer contact details for documents:

- N/A

Health and Wellbeing Board 29 September 2015	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Charter for Homeless Health (St Mungo's Broadway)	

Lead Officer	Somen Banerjee, Director of Public Health
Contact Officers	Martin Ling, Housing Strategy and Partnerships Manager Paul Wishart, Vulnerable Adults Commissioning Team, Commissioning Manager Adults Services Tim Madelin, Senior Strategist Public Health
Executive Key Decision?	No

Summary

St Mungo's Broadway is a national level homelessness charity that has contacted Health and Wellbeing Boards across the country to request that they consider signing the Charter for Homeless Health

The Charter seeks commitment from the Health and Wellbeing Board

- to include the needs of people who are homeless in the Joint Strategic Needs Assessment
- to provide leadership across the partnership to address homeless health
- to ensure that across the local authority and clinical commissioning group, local health services meet the needs of people who are homeless (commissioning for inclusion)

This report outlines at a high level the homelessness strategy and specific initiatives to meet the health needs of people who are homeless.

The commitments of the Charter are in line with existing work and it is recommended for the Health and Wellbeing Board to sign the Charter in order to demonstrate continued partnership commitment to working together to protect and improve the health of people who are homeless.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Sign the Charter for homeless health

1. REASONS FOR THE DECISIONS

1.1 To publicly demonstrated partnership commitment to improving the health of people who are homeless

2. ALTERNATIVE OPTIONS

2.1 Not to sign

3. DETAILS OF REPORT

Background

3.1 St Mungo's Broadway is a national level homelessness charity which runs a range of initiatives for homeless people including housing , advice, health and employment services

3.2 The organisation, in its campaigning role, has been contacting Health and Wellbeing Boards across the country to sign the Charter for Homeless Health.

3.3 This recognises the substantially worse health of people who are homeless. The average age of death for a homeless person is 47 which is around 30 years lower than the national average.

3.4 Underpinning this are very high levels of physical and, particularly, mental health issues coupled with substantial barriers to accessing basic health and social care services.

3.5 The charter seeks commitment from the Health and Wellbeing Board

- to include the needs of people who are homeless in the Joint Strategic Needs Assessment
- to provide leadership across the partnership to address homeless health (noting the lead role of the Director of Public Health)
- to ensure that across the local authority and clinical commissioning group, local health services meet the needs of people who are homeless (commissioning for inclusion)

Homelessness in Tower Hamlets

3.6 Based on public health outcomes framework data, there were 1,935 households in temporary households in Tower Hamlets in 13/14 (equating to a rate of 17.7 per 1000 population – the ninth highest in London). There were 377 people seen sleeping rough in 14/15. There is an existing Homelessness and Health JSNA and the data is currently being refreshed.

3.7 The Council and its partners are continually striving to improve services and reduce homelessness in the borough through strong partnership working. The

emphasis continues to be on preventative case work intervention in order to reduce statutory homeless acceptances.

3.8 In addition the Council has extended services to single “non-statutory” homeless people and reduced the number of people sleeping rough under the No Second Night Out initiative whilst working with the hostel sector to ensure they are more responsive to the needs of the borough, with the neediest and vulnerable prioritised for vacancies

3.9 Since 2011 the Council has attempted to reduce the use of temporary accommodation and bed and breakfast for homeless households but the introduction of welfare reforms and the heated private sector housing market has provided significant barriers.

3.10 The Council is about to refresh its current homelessness statement which was adopted in 2013. The overall aim of the statement is to tackle and prevent homelessness in Tower Hamlets, which includes: preventing homelessness; supporting those who are homeless or at risk of homelessness; and providing accommodation for homeless households.

3.11 This will be achieved through four strategic themes which will be retained for the 2105/16 refresh:

- Focus on homeless prevention and tackling the root causes of homelessness
- Access to affordable housing options;
- Children, families and young people; and
- Supporting vulnerable adults

3.12 There are a range of health specific initiatives to improve the health of people who are homeless including

- The London Pathway model at the Royal London ensures those who are homeless or insecurely house and who access hospital, are moved on as speedily and effectively as possible through a multi-agency approach
- Health E1 is a primary care practice for vulnerable homeless people and those in hostels, day centres or supported by the London Pathway project

What is the added value of signing up to the Charter?

3.13 Signing up to the charter demonstrates recognition at the highest level of the importance of the issue of health and homelessness and a commitment to addressing the health needs of people who are homeless

3.14 The Charter provides impetus to track progress around the three key elements of its framework – identifying need, providing leadership and commissioning for inclusion

3.15 As part of a network of other Health and Wellbeing Boards across the country (currently 32) there will be an opportunity to share information, guidance and case studies

Recommendation

3.16 It is recommended to sign up for the Charter and ensure that the commitments continue to underpin council and CCG strategies and commissioning to address the needs of people who are homeless.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The commitments in the Charter are in line with existing work, there are no additional financial implications as a result of the recommendations in this report.

5. LEGAL COMMENTS

5.1 The Health and Social Care Act 2012 ("the 2012 Act") makes it a requirement for the Council to establish a Health and Wellbeing Board ("HWB"). S.195 of the 2012 Act requires the HWB to encourage persons who arrange for the provision of any health or social care services in their area to work in an integrated manner.

5.2 This duty is reflected in the Council's constitutional arrangements for the HWB which states it is a function of the HWB to have oversight of the quality, safety, and performance mechanisms operated by its member organisations, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health.

5.3 Further, it is a function of the HWB to identify the needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning and policy decisions are based on evidence.

5.4 Additionally, under the Care Act 2014 the Council has a number of general duties in ss.1-7 including a duty to co-operate generally with those it considers appropriate who are engaged in the Council's area relating to adults with needs for care and support. Further, there is a general duty to prevent needs for care and support from developing.

5.5 The Council has broad powers to provide different types of accommodation in order to meet people's needs for care and support. The Act is clear that suitable accommodation can be one way of meeting care and supports needs. However, the Act is also clear on the limits of responsibilities and relationship between care and support and housing legislation, to ensure that there is no overlap or confusion. Section 23 of the Act clarifies the existing boundary in law between care and support relevant housing legislation, such as the Housing Act 1996. Where the Council is required to meet accommodation

related needs under housing legislation as set out in the Housing Act 1996 or under any other legislation specified in regulations then the Council must meet those needs under that housing legislation.

5.6 The aims of the Charter may assist with the Council's general duties and is within the functions of the HWB.

5.7 When considering the recommendation regard must be given to the public sector equalities duty to eliminate unlawful conduct under the Equality Act 2010. The duty is set out at Section 149 of the 2010 Act. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

5.8 In light of the equality duty consideration may be given to other initiatives and charters seeking the same aims.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 This is a proposal that relates to improving the health of people who have the poorest health in the borough

7. BEST VALUE (BV) IMPLICATIONS

7.1 No direct implications although the proposal encourages partnership working between commissioners and providers of services to meet the needs of people who are homeless and this could promote efficiencies

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 No direct implications

9. RISK MANAGEMENT IMPLICATIONS

9.1 The commitments in the charter are very much in line with Council and NHS approaches to addressing health and homelessness so there are no obvious risks

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 Reducing homelessness would be expected to have positive impacts on crime and disorder

Linked Reports, Appendices and Background Documents

Linked Report

- [List any linked reports, for example those that went to other Committees on the same issue]
- State NONE if none.

Appendices

- Charter for homeless health

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- State NONE if none.

Officer contact details for documents:

- Somen Banerjee, Director of Public Health

A Future Now
Demanding action on homelessness

St Mungo's Broadway
Rebuilding lives, day by day

Charter for homeless health

People who are homeless face some of the worst health inequalities in society. They are at much greater risk of mental and physical health problems than the general population and their experiences of homelessness often make it more difficult to access the healthcare they need.

The ..... **Health and Wellbeing Board** is committed to changing this. We therefore commit to:

Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

Commission for inclusion: We will work with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

Signed: .....

Chair: ..... **Health and Wellbeing Board**

Date: .....

St Mungo's Broadway, Griffin House, 161 Hammersmith Road, London W6 8BS
St Mungo Community Housing Association is a registered charity and a limited company registered in England and Wales
Registered Charity No. 1149085 Company No. 8225808 Housing Association No. LH0279

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